
Report to:
State of Alaska
Senate Finance Committee

MEDICAID PROGRAM REVIEW



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TABLE OF CONTENTS

	<u>Page</u>
Executive Summary	1
Scope of Work	1
Summary of Findings & Recommendations	2
Chapter 1: Introduction	9
Scope of Work	9
Report Structure	13
Chapter 2: Demographics & Medicaid Eligibility	14
Introduction	15
Federal Medicaid Eligibility Requirements	15
Alaska Medicaid Eligibility	18
50-State Eligibility Analysis: How Does Alaska Compare?.....	22
Eligibility – Findings & Recommendations	34
Chapter 3: Covered Services	35
Introduction	36
Mandatory & Optional Services	36
50-State Expenditure Analysis: How Does Alaska Compare?...	39
Cost Containment	44
Hospital Services	48
Physician/Clinic Services	54
Pharmacy	58
Long-Term Care	66
Behavioral Health	80
Covered Services – Findings & Recommendations	82
Chapter 4: Tribal Health	84
Introduction	85
Overview of the Tribal Health System	85
Support for the Alaska Tribal Health System	89
Broad-Based Reform	89
Chapter 5: Medicaid Administration	91
Introduction	92
Department of Health & Social Services	92
50-State Analysis: How Does Alaska Compare?	94
Medicaid Eligibility Determination	97
Program Integrity & Provider Payment Errors	98
Regulatory Comparison	101
Administrative Findings & Recommendations	104

TABLE OF CONTENTS – cont'd

	<u>Page</u>
Chapter 6: Recommendations for Reform	105
Introduction	105
Development of a Comprehensive Reform Plan	106
Moving Beyond Traditional Cost Containment	106
Expansion of Medicaid-Covered Populations & Services	108
Pay-for-Performance	112
Disease Management/Care Coordination	114
Managed Health Care Approaches	117
Premium Assistance Programs for	
Employer-Sponsored Insurance (ESI)	119
Health Savings Accounts (HSAs)	122
Financing of Health Care for American Indians/ Alaska Natives	125
Comprehensive Reform – Implementation Considerations	127

Appendix A: Supplementary Tables

A01 – Distribution of Medicaid Enrollees by Enrollment Group	A-1
A02 – Presumptive Eligibility under Medicaid for Pregnant Women	A-3
A03 – Distribution of Total Population by Federal Poverty Level	A-5
A04 – Poverty Rate by Age	A-7
A05 – Unemployment Rate (Seasonally Adjusted)	A-9
A06 – Distribution of Workers by Permanent & Temporary Work Status	A-11
A07 – Number of Occupational Fatalities per 100,000 Workers	A-13
A08 – Percent of Children Who Are Immunized	A-15
A09 – Percent of Children ... Who Received Mental Health Care	A-17
A10 – Rate of Teen Deaths by Accident, Homicide & Suicide	A-19
A11 – Percent of Adults with a Disability	A-21
A12 – Hospital Beds per 1,000 Population	A-23
A13 – Hospital Admissions per 1,000 Population	A-25
A14 – Hospital Inpatient Days per 1,000 Population	A-27
A15 – Hospital Outpatient Visits per 1,000 Population	A-29
A16 – Hospital Emergency Room Visits per 1,000 Population	A-31
A17 – Rate of Nonfederal Physicians per 100,000 Population	A-33
A18 – Retail Prescription Drugs Filled at Pharmacies (per Capita)	A-35
A19 – Retail Prescription Drugs Filled at Pharmacies (per Capita by Age)	A-37
A20 – Distribution of Certified Nursing Facility (NF) Residents by Medicaid	A-39
A21 – Total Certified NF Residents ... Population 65 Years & Older	A-41
A22 – Total Nursing Staff Hours per Resident Day in all Certified NF	A-43
A23 – Average Number of Deficiencies per Certified Nursing Facility	A-45
A24 – Number of State & County Psychiatric Hospital Inpatient Beds	A-47

Appendix B: Crosswalk of State/Federal Regulations **B-1**

EXECUTIVE SUMMARY

Medicaid is a critical component of the Alaska health care system, responsible for providing health coverage to nearly one-in-five of the state's residents, including one-third of Alaska's children. It is also a program confronting major challenges.

In state fiscal year 2005, Medicaid expenditures for the first time exceeded \$1 billion in state and federal funds. Although the rate of spending growth slowed last year, a recent report commissioned by the Department of Health and Social Services (DHSS) concluded that over the next five years, "Medicaid spending by the state is projected to grow at a faster rate than the Alaska economy (GSP) and faster than total personal income in the state." Some of the underlying factors driving this growth – such as Alaska's aging population – will continue into the next decade and beyond.

Scope of Work

The Pacific Health Policy Group (PHPG) was retained by the Alaska Senate Finance Committee to conduct an analysis of Alaska Medicaid and make recommendations for enhancing program accountability and cost containment, while ensuring the state continues to provide necessary services to the Alaska's most vulnerable citizens.

The Senate Finance Committee defined three specific tasks for the engagement:

1. *50-State Ranking:* PHPG compared Alaska's Medicaid eligibility standards and benefit packages to those in the 49 other states. As part of this evaluation, PHPG also researched best practices in other states with respect to service delivery and financing, cost containment strategies and administrative procedures.
2. *Internal Alaska Evaluation:* PHPG reviewed Alaska's Medicaid State Plan, statutes and regulations to identify any unclear or conflicting provisions that could lead to misinterpretations, inappropriate eligibility determinations, or areas of noncompliance with federal law or regulation. PHPG also conducted a high-level review of DHSS's organizational structure and administrative costs and reviewed the state's strategy for procuring a new Medicaid Management Information System (MMIS) vendor.

3. *Reform Options:* PHPG examined opportunities for strengthening the Medicaid program, both incremental and broad-based (structural).

Summary of Findings & Recommendations

The findings and recommendations presented below are discussed in greater detail in Chapters 2 – 6. Medicaid eligibility is addressed first, followed by covered services, tribal health care, program administration and reform options.

Medicaid Eligibility

Medicaid covers five major low-income groups – children, pregnant women, parents, the elderly and the disabled. The federal government has established minimum eligibility standards within each of the five major groups, and states must offer Medicaid at least up to these standards as a condition of receiving federal matching dollars. The populations falling within these minimum standards are commonly referred to as “mandatory” coverage groups and primarily include persons who, prior to welfare reform, often qualified for Medicaid as an adjunct to receiving some type of cash assistance (e.g. AFDC payment or SSI payment).

States are not limited to enrolling the mandatory populations, but have the latitude to extend coverage to other “categorically or medically needy optional coverage groups”. These optional groups consist of persons who would qualify as part of a mandatory group except they live in households with incomes above the mandatory limits.

Alaska ranks in the middle tier of states, in terms of the optional coverage groups the state includes in Medicaid. Alaska’s optional Medicaid population accounts for about 30 percent of all enrollees and 30 percent of all medical costs.

Although Alaska is comparable to other states in its coverage policies, the state did experience faster than average enrollment growth in recent years. Medicaid today is the second largest health insurance payer in the state, while nationally it ranks third.

In sheer numbers, Medicaid is primarily a program for children and pregnant women, and Alaska’s historically younger profile has contributed to the size of the state’s Medicaid program. At the same time, Alaska’s elderly population is growing quickly, and the state is going to confront new challenges in the form of larger numbers of Medicaid-eligible frail

elderly and disabled residents in coming years. This will place pressures on the state's long-term care system, which is already under stress.

Alaska also has a large uninsured population, which contributes to the level of uncompensated care in the state. The Department of Health and Social Services (DHSS) does operate a state-funded program, known as Chronic and Acute Medical Assistance, or CAMA, which serves as a payer of last resort for individuals with chronic or life-threatening conditions who meet program eligibility standards.

Alaska's qualifying conditions for CAMA are consistent with the types of conditions covered in medically needy programs, as well as Section 1115a research and demonstration waiver programs in some other states. Under such demonstrations, states are able to secure federal matching funds while capping enrollment, state expenditures or both.

In state fiscal year 2004, the CAMA program served 1,522 persons. Program expenditures totaled \$2.2 million, of which about three-quarters went for prescription drugs and most of the remainder for hospital and physician services. If this group was enrolled under a research and demonstration waiver – either for a pharmacy-only benefit or for all services – state expenditures could be used to draw down funds to serve additional persons. Alternately, the federal matching funds could be used to reduce state expenditures by about \$1.3 million (at the current federal matching rate).

Covered Services

State Medicaid programs must make available a federally-defined package of “mandatory services” to categorically needy beneficiaries (the only type enrolled in Alaska Medicaid) and may, at their choosing, supplement the mandatory services with one or more federally-recognized “optional services”. Alaska is comparable to other states in terms of the optional Medicaid services it offers. Alaska actually spends less on optional services – as a percentage of total care dollars – than most other states.

Alaska's program is expensive, compared to other states. Adjusting for cost of living differences, Alaska spent \$1,200 more per enrollee than the national average in 2003 (the most recent year for which national data is available). Spending within individual service categories – hospital, physician, pharmacy and long-term care – also ranks near the top on a per beneficiary basis.

Program costs grew at double digit rates in the first part of the decade. Although spending growth has slowed of late, DHSS's long-term forecast projects it will return to near double digit levels again before the end of the decade.

DHSS has taken a number of steps to contain costs, consistent with actions in the other 49 states, all of whom also face budget pressures within their Medicaid programs. Opportunities exist for additional cost containment in selected areas – particularly pharmacy and long-term care.

Medicaid's pharmacy program has instituted a preferred drug list and other controls in the past two years intended to curb the upward growth spiral. The program's payment rates to pharmacies, however, are among the highest in the nation. This may be an appropriate payment policy for critical access pharmacies serving as sole community providers, but the state should explore using tiered pricing to secure discounts from larger chain drug stores in urban areas such as Anchorage. The pharmacy program also should move quickly to expand a just-introduced prior authorization process currently in force for only a portion of covered prescriptions.

Medicaid's long-term care program serves two distinct populations – the elderly/physically disabled and the developmentally disabled. The first group is growing in size along with the aging of the state's population. In recent years, enrollees in the two home- and community-based waiver programs for the elderly and physically disabled have driven up costs in the Personal Care Attendant program, which exists outside of the waiver and is not subject to the same controls. This bifurcated system has had the dual effect of driving up costs while impeding good care management.

The state has put in place some controls specifically for Personal Care. However, it would be best served by establishing a strong, up-front screening process that looks at all care components together, and directs services to persons who truly meet the long-term care standard of need. At the same time, new, lower cost community-based service options for persons with mild dementia and manageable physical deficits should be explored. This is a process that will take some time; Medicaid should act now before the elderly population's growth outstrips the state's ability to serve everyone who needs care.

The state's issues with respect to the developmentally disabled are different. A significant number of services are provided with state-only dollars to persons on the DD waiver waiting

lists and persons with developmental disabilities who do not qualify for the waiver. The state should consider extending Medicaid coverage to these persons, thereby securing federal matching dollars. This could be done either by enlarging the current waiver or creating a new waiver with services matching those available today through the state-only program.

Not every program area shows the same potential for additional cost containment. Physician and clinic fees, while high, appear to be supporting the broader ambulatory health care infrastructure.

Behavioral health is being transformed to some extent through the Bring the Kids Home Initiative. However, it lacks significant investments in preventive/early intervention services which, if made, could eventually reduce the need for more expensive institutional services.

Tribal Health Care

Native Alaskans account for nearly four-in-ten Medicaid beneficiaries, by far the largest Native American segment of any state Medicaid program. In fiscal year 2005, the program included 52,000 American Indian/Alaska Native (AI/AN) enrollees, an increase of 3.6 percent from the previous year. The number actually receiving services grew by 5.2 percent.

The great majority of Alaska Natives live in rural areas, many in remote villages with fewer than 300 residents. The health status of the AI/AN is significantly worse than that of the general population, with higher incidences of tuberculosis, diabetes and other serious health conditions. Alaska Natives are reliant for most of their care on a tribal health system that is increasingly under strain.

Alaska tribes govern and operate the tribal health system under a statewide compact. Tribes may operate independently or may designate a single entity to operate the health care delivery system. Federal law (PL93-638) authorized tribal providers to take over facilities of the Indian Health Service (IHS); these “638” providers develop annual funding agreements with IHS. The Indian Health Service provides approximately \$440 million in funding annually, representing about 60 percent of the tribal system’s total annual budget.

Various treaties, judicial opinions, federal statutes, executive orders and other measures establish an obligation on the part of the federal government to provide health care to tribal members. For this reason, Medicaid payments to tribal providers are paid with 100 percent federal funds.

However, IHS, unlike Medicaid or Medicare, is not an entitlement under federal statute, and is therefore subject to the annual federal budget process. IHS funding for the Alaska tribal health system increases one to two percent per year, while the tribal system's expenses have been growing at a rate of approximately eight to nine percent per year.

In federal fiscal year 2005, Medicaid payments to tribal providers amounted to approximately \$180 million. However, Medicaid paid another \$220 million to non-tribal providers at the regular federal matching rate. Most of the non-tribal expenditures went for three services: inpatient hospital, behavioral health and long-term care.

It would be in the state's interest, from both a financial and quality of service perspective, to actively participate in establishing greater capacity among tribal providers, particularly with respect to long-term care. For example, the Alaska Medicaid program spends approximately \$19 million for non-tribal nursing facility services provided to AI/ANs, of which approximately \$8 million is state matching funds. If Alaska were to provide financial support for development of tribal health long-term capacity, the potential state savings could be significant.

Alaska also may want to consider collaborating with tribal providers on a broader re-organization of the tribal health care delivery system that would permit it to be recognized by the federal government as a managed care entity. Under this arrangement, which could continue to resemble the current system from an operational standpoint, Medicaid funding to the tribal health plan would be based on the full range of Medicaid-eligible services for Medicaid-eligible Native Alaskans. Subject to negotiation with the federal government, such payments could potentially be 100 percent federally funded, thereby removing most or all of the state's current expenditures.

In exchange for payment, the tribal health entity would be responsible for ensuring access and delivery of all Medicaid-eligible services, including sub-contracting with non-tribal providers (who could still be permitted to bill and receive payment through the MMIS). The tribal health entity, in return, would have the opportunity to re-invest monies into health promotion, disease prevention and culturally-appropriate community-based care initiatives intended over the long term to improve access to services in rural communities, while lowering costs.

Program Administration

Alaska's Medicaid administrative costs on a per eligible basis are much higher than most states', though this is at least partly due to the program's small enrollment base and geographic challenges.

The federal government monitors state Medicaid agencies with respect to their accuracy rates for eligibility determination and claims payment. Alaska's program appears to meet CMS standards for eligibility determination, but faces challenges in preparing for new federal payment accuracy audits (known as "PERM") scheduled to begin in 2008.

DHSS performed an internal audit to help prepare for the federal audit and identified three priority areas – Dental, DME and therapies. The legislature should seek regular updates on activities in 2007 to prepare in these three areas and program-wide for the federal audits. States that fail the audits could be at risk of losing millions of dollars in federal payments, through disallowances.

Concurrent with its preparation for the PERM audit, DHSS will be overseeing the handover of its MMIS to a new contractor. The RFP lays out an aggressive timetable for the new contractor to design, develop and implement its system, while potentially taking over operation of the current MMIS from First Health. The legislature should seek regular updates of this process as well, and use the contractor deliverable schedule outlined in the RFP as a guide for determining if the process is on schedule.

As part of our scope of work, PHPG also reviewed the department's recently-issued draft regulations for covered services. We found them in compliance with federal law and regulations and identified only a few areas for potential follow-up by DHSS.

Program Reform Options

Over the past five years the federal government has shown a greater willingness to provide states with the flexibility to restructure their programs and adopt new financing and health care delivery methods intended to bring greater control over program budgets. The government has done so in two ways – through the Deficit Reduction Act of 2005 (DRA) and the Section 1115a waiver process.

Alaska has recognized the importance of program planning and evaluation, as evidenced by recent studies to forecast program expenditures and assess the long-term care system. These studies indicate that program change is inevitable; the program as it exists today is not financially sustainable over the long term. The logical next step is to develop a comprehensive approach for program reform.

Chapter 6 of the report reviews a number of private sector-oriented reforms being tested in other states, as part of DRA initiatives or Section 1115a waivers. These include both incremental measures – such as introduction of employer-sponsored coverage initiatives and disease management programs – and broader reforms.

For example, Vermont in 2004 negotiated a global cap on its program, locking in federal financial participation up to a pre-defined level. The state also received federal match for services that previously had been funded with state dollars only and was granted the flexibility to change coverage conditions for optional Medicaid groups without, in most cases, filing state plan amendments or seeking federal approval.

Ultimately, the decision over whether to take incremental steps or pursue a waiver should be made based on what Alaska hopes to achieve through Medicaid reform. The reform planning process should begin at the broadest possible level, working towards a reform plan that best meets Alaska's programmatic and fiscal objectives. Once the reform plan has been developed, an assessment can be made to determine what aspects of the plan may be implemented within the parameters of federal regulations and what aspect would require federal waiver authority. Alaska then would be in a position to determine the best approach for securing federal approval of its plan.

CHAPTER 1 – INTRODUCTION

Medicaid is the country's primary source of health coverage for low-income families and persons with disabilities. In 2005, nearly 40 million Americans were covered by the program for at least part of the year.

Medicaid is similarly a critical component of the Alaska health care system, responsible for providing health coverage to nearly one-in-five of the state's residents, including one-third of Alaska's children. It is also a program confronting major challenges.

In state fiscal year 2005, Medicaid expenditures for the first time exceeded \$1 billion in state and federal funds. Although the rate of spending growth slowed last year, a recent report commissioned by the Department of Health and Social Services (DHSS) concluded that over the next five years, "Medicaid spending by the state is projected to grow at a faster rate than the Alaska economy (GSP) and faster than total personal income in the state."¹ Some of the underlying factors driving this growth – such as Alaska's aging population – will continue into the next decade and beyond.

The Pacific Health Policy Group (PHPG) was retained by the Alaska Senate Finance Committee to conduct an analysis of Alaska Medicaid and make recommendations for enhancing program accountability and cost containment, while ensuring the state continues to provide necessary services to the Alaska's most vulnerable citizens. PHPG is an Irvine, California-based consulting firm specializing in the evaluation and reform of state Medicaid programs.

The Senate Finance Committee defined three specific tasks for the engagement, as described below.

Scope of Work

Task 1 – 50-State Ranking of Eligible Services & Best Practices

In Task 1, PHPG compared Alaska's Medicaid eligibility standards and benefit packages to those in the 49 other states. PHPG documented the extent to which Alaska exceeds federal

¹ "Long-Term Forecast of Medicaid Spending in Alaska: 2005 – 2025", The Lewin Group and ECONorthwest, page 86

minimum standards by extending coverage to optional Medicaid populations and making available optional services. As part of this evaluation, PHPG also researched best practices in other states with respect to service delivery and financing, cost containment strategies and administrative procedures.

To better understand the issues confronting Alaska Medicaid, and to document current administrative practices within DHSS, PHPG consultants met with a variety of representatives from state government, provider organizations and stakeholder groups. The meetings also were used to explore potential areas for program reform. It should be noted that PHPG did not undertake a formal audit of DHSS and its processes; rather, the meetings were used to gain a high-level understanding of how the program works today and how it could be improved.

Exhibit 1-1 below identifies the state departments and divisions, and non-governmental organizations, interviewed as part of the study.

Exhibit 1-1 – Department/Division & Stakeholder Interviews

State Departments/Divisions	Other Organizations
DHSS – Developmental and LTC Services	Alaska Behavioral Health Association
DHSS – Division of Financial Management	Alaska Native Tribal Health Consortium
DHSS – Division of Health Care Services	Alaska Primary Care Association
DHSS – Division of Mental Health & Substance Abuse	Alaska Regional Health Consortium
DHSS – Pharmacy Services	Alaska State Medical Association
DHSS – Division of Program Integrity	Anchorage Community Mental Health Services
DHSS – Division of Public Assistance	Eastern Aleutian Tribes, Incorporated
DHSS – Division of Rate Setting	Mat-Su Regional Medical Center
DHSS – Division of Regulatory Compliance & Certificate of Need	Providence Health System
DHSS – Tribal Health	
Department of Law – Attorney General’s Office	
Department of Revenue – Alaska Mental Health Trust Authority	

PHPG’s program-level evaluation was conducted shortly after the completion of several other independent studies that examined specific components of the Medicaid program.

These included in-depth evaluations of the behavioral health² and long-term care³ systems, as well as a long-range forecasting study that developed program enrollment and expenditure projections (assuming no change in policies)⁴. PHPG's work was informed by findings and recommendations from these earlier studies, as discussed in later chapters.

Task 2 – Internal Alaska Comparison

In Task 2, PHPG reviewed Alaska's Medicaid State Plan, statutes and regulations to identify any unclear or conflicting provisions that could lead to misinterpretations, inappropriate eligibility determinations, or areas of noncompliance with federal law or regulation.

The regulatory analysis was conducted by constructing a crosswalk between Alaska and federal regulations addressing covered services⁵ and using the crosswalk to ascertain if Alaska's rules conflict with federal requirements in any areas. State regulations for both eligibility determination and covered services also were reviewed against actual program operations, as described in interviews with DHSS staff, to identify any inconsistencies.

The regulatory analysis was conducted using proposed regulations released in July 2006 for public comment by DHSS, rather than the regulations currently in force. The revised regulations represent the culmination of a multi-year effort by DHSS to bring greater clarity and structure to Medicaid regulations, and are close to final adoption.

As a component of Task 2, PHPG also conducted a high level review of DHSS's organizational structure and administrative costs, and examined recently issued reports concerning Alaska's Medicaid eligibility determination and payment error rates, administrative controls and fraud and abuse-related activities. This evaluation was coupled with a review of the state's strategy for procuring a new Medicaid Management Information System (MMIS) vendor.

² "Alaska Behavioral Health Integration", *Information Insights* (2004)

³ "Alaska Long-Term Care and Cost Study Final Report", *Public Consulting Group* (2006)

⁴ "Long-Term Forecast of Medicaid Enrollment and Spending in Alaska" 2005 – 2025", *The Lewin Group and ECONorthwest* (2006)

⁵ PHPG's original scope of work called for constructing a crosswalk between state and federal regulations governing both eligibility and covered services. However, early in the engagement it was learned that DHSS already had constructed a crosswalk for eligibility regulations, making this task unnecessary. Instead, PHPG performed spot checks on the eligibility crosswalk to verify its accuracy.

Task 3 – Professional Consultation Regarding Reform Options

In Task 3, PHPG examined opportunities for reforming the Medicaid program, including with respect to four services singled-out in the Request for Proposals: Pharmacy, Nursing Services, Personal Care Attendant services and Long-Term Care Waiver programs. PHPG also evaluated the potential benefit to Alaska – based on findings from Tasks 1 and 2 – of pursuing one or more innovations to the program’s existing eligibility, service delivery and financing structure.

These innovations, as outlined in the RFP, included:

- Developing public/private partnerships between Medicaid and employers
- Introducing managed care, to the extent feasible, given Alaska’s demographics and insurance industry
- Enacting cost sharing reforms, including charging premiums for enhanced benefits or adopting tiered premiums or co-payments based on income
- Adopting market-based reforms, such as Health Savings Accounts
- Containing cost, by placing caps on optional programs, such as long-term care waivers, or on the entire Medicaid program
- Increasing federal financial participation, by obtaining federal matching dollars for services funded today with state dollars only
- Strengthening the tribal health system, through adoption of best practices from other states with respect to tribal health and rural health care delivery in general

Based on the findings from all three tasks, PHPG formulated a comprehensive set of recommendations for strengthening the Alaska Medicaid program in accordance with the Legislature’s objectives. These recommendations are intended to provide the state with a roadmap for improving services in an era of cost containment.

Report Structure

Each chapter of the report begins with a summary of key findings. These findings form the basis for our recommendations to restructure and strengthen Medicaid, and to give greater flexibility to state policymakers to control costs while targeting resources toward those most in need.

Chapter 2 of the report examines Alaska's demographic characteristics and current Medicaid eligibility standards, including standards for optional coverage groups. The chapter also compares Alaska's eligibility standards and enrollment trends with those of the 49 other states.

Chapter 3 of the report examines covered services. The chapter catalogs the package of mandatory and optional Medicaid services offered in Alaska and the 49 other states, and reviews expenditure trends at the program level. The chapter then explores in detail payment and service delivery practices within five major service categories: hospital, physician, pharmacy, long-term care (nursing facilities, Pioneer Homes, personal care attendant, HCBS waivers) and behavioral health.

Chapter 4 of the report focuses on Alaska's tribal health care system in a stand alone section. Alaska has the country's largest number of Native American Medicaid enrollees and, to succeed, any reform strategy must address tribal health.

Chapter 5 covers program administration, including DHSS's organizational structure and administrative costs. The chapter also examines issues related to eligibility determination, program integrity, payment accuracy and the Medicaid Management Information System.

Chapter 6 summarizes PHPG's major findings and presents our recommendations for strengthening the Medicaid program. The recommendations are segmented into two categories – incremental and structural.

The report also contains two appendices. Appendix A contains a series of tables with data on the 50-state Medicaid programs not presented in the body of the report.

Appendix B contains the crosswalk between Alaska and federal regulations for covered services.

CHAPTER 2 – DEMOGRAPHICS & MEDICAID ELIGIBILITY

Key Findings

- ✓ Alaska ranks in the middle tier of states, in terms of the optional coverage groups included in Medicaid
- ✓ The program historically has been composed of children and pregnant women and relatively few disabled and elderly
- ✓ Broader demographic trends will result in a shift toward many more elderly – and more disabled – enrollees than the state has seen in the past
- ✓ The enrollment shift will result in a greater need for long-term care services, and a resultant push toward higher program costs
- ✓ The state has time to act before this shift fully occurs to restructure elements of the chronic care and long-term care system to make more effective use of state dollars
- ✓ CAMA dollars could be used to secure federal matching funds without creating a new entitled group
- ✓ The long-term care program could be used to secure more federal funds, while targeting those funds in a more effective manner, as outlined in Chapter 3
- ✓ The state also could gain control over eligibility – and obtain more operational flexibility – by replacing the traditional Medicaid program with a Section 1115a research and demonstration program, as outlined in Chapter 6

Introduction

This chapter examines Alaska’s demographics and Medicaid eligibility standards, and documents the size and relative importance of the state’s optional coverage groups. Alaska’s program is then compared to programs in the other 49 states and District of Columbia. The chapter also includes a review of DHSS eligibility policies and practices. It concludes with a brief summary of findings and a discussion of potential reforms within eligibility that would occur as part of a broader restructuring of the program. (Full recommendations are presented in Chapter 6.)

Federal Medicaid Eligibility Requirements

The federal government established the Medicaid program in 1965. In the 41 years since, Congress has periodically enacted legislation creating new eligibility categories or altering eligibility criteria for existing coverage groups. In its most sweeping change, in 1996, Congress enacted the Personal Responsibility and Work Opportunity Reconciliation Act, or welfare reform, severing the link between Medicaid and cash assistance.

Medicaid covers five major low-income groups – children, pregnant women, parents, the elderly and the disabled – but there are over 20 discrete categories of eligibility spread across these five groups, each with its own set of eligibility criteria defined in federal law and regulations. In recent years, the federal government also has created a small number of “special coverage groups”, including women with breast or cervical cancer.

States must collect and evaluate a large amount of information from prospective enrollees in order to determine eligibility. Although Medicaid eligibility is most frequently described in terms of income (e.g., percentage of the Federal Poverty Level, or FPL) – and this benchmark will be used throughout the chapter – other factors affecting eligibility include household size and composition (e.g., whether there are children in the household); household assets and expenses; and whether an individual has been determined disabled by the Social Security Administration.

The federal government has established minimum eligibility standards within each of the five major groups, and states must offer Medicaid at least up to these standards as a condition of receiving federal matching dollars. The populations falling within these minimum standards are commonly referred to as “mandatory” coverage groups and primarily include persons

who, prior to welfare reform, often qualified for Medicaid as an adjunct to receiving some type of cash assistance (e.g., AFDC payment or SSI payment).

States are not limited to enrolling the mandatory populations, but have the latitude to extend coverage to other low-income populations through either of two mechanisms. First, states are permitted by federal statute to add one or more “optional” coverage groups to their programs. These optional groups consist of persons who would qualify as part of a mandatory group except they live in households with incomes above the mandatory limits. For example, states must cover pregnant women in households at or below 133 percent of the FPL; states may cover pregnant women with incomes above the 133 percent limit. (The mandatory populations and their higher income-optional counterparts are sometimes referred to as the “categorically needy”, because they fall within one of the federally-defined categories of eligibility – such as pregnancy.)

Federal statute recognizes one other optional coverage category, known as the “medically needy”. These are persons whose income (and/or resources) exceeds the categorically-needy limits, but who incur medical expenses sufficient to qualify for Medicaid on that basis. Every state covers some categorically-needy optional populations, but many states – including Alaska – do not have a medically-needy option within their Medicaid programs.

Exhibit 2-1 on the next page summarizes the major mandatory and optional Medicaid coverage groups.

Exhibit 2-1 – Federally-Defined Coverage Groups

Mandatory Group	Optional Group
1) Children under age 6 in households with income below 133 percent of FPL ⁶ (\$21,945 for a family of two in Alaska)	1) Children under age 6 in households at or above 133 percent of FPL ⁷
2) Children ages 6 and older in households with income below 100 percent of FPL (\$16,500 for a family of two)	2) Children ages 6 and older in households at or above 100 percent of FPL
3) Parents at or below a state's AFDC cutoffs from July 1996, when welfare reform was enacted (75 percent of FPL for non-working parents; 81 percent for working parents)	3) Low-income parents above the state's AFDC cutoff
4) Pregnant women at or below 133 percent of FPL	4) Pregnant women above 133 percent of FPL
5) Aged, blind and disabled SSI beneficiaries with income below 75 percent of FPL (\$9,188 for a household of one)	5) Aged, blind and disabled beneficiaries between 75 and 100 percent of FPL
6) Working disabled persons at or below SSI limits	6) Working disabled above SSI limits
7) Medicare eligibles above SSI limits qualifying for limited benefits (QMB, SLMB and QI groups)	7) Nursing home residents above SSI limits but below 300 percent of SSI
	8) Individuals at risk of needing nursing facility or ICF/MR placement but served through an HCBS waiver
	9) Women with breast or cervical cancer
	10) Medically needy individuals

When states elect to cover one of the optional groups recognized in federal statutes, they amend their Medicaid state plans in accordance with federal guidelines. The Medicaid state plan effectively serves as the contract between a state and the federal government, defining who is covered in that state's program and for what services. Most of the language and organizational structure in the state plans is prescribed by the federal government, with states

⁶ Alaska and Hawaii have state-specific federal poverty level (FPL) thresholds, while the other 48 states share a common threshold. In 2006, 100 percent of the FPL in Alaska for a single individual equaled \$12,250, versus \$11,270 in Hawaii and \$9,800 in the rest of the country.

⁷ States can enroll children in households above the mandatory limits into a separate State Child Health Insurance Program (SCHIP) as long as the SCHIP component is limited to income levels above what was already covered under Medicaid at the time of SCHIP's enactment. In Alaska, Denali KidCare operates as a separate SCHIP program.

often limited to a choice of check boxes within a particular section. After 40 years, the Medicaid state plans are nearly as complex as the program itself, but states have no authority to simplify or re-organize the documents to better meet their needs.

However, the state plan amendment process is not the only mechanism available for altering a state Medicaid program. Section 1115a of the Social Security Act gives the Secretary of the US Department of Health and Human Services authority to grant broad-based “research and demonstration” waivers to states seeking to transform their Medicaid systems.⁸ In the early and mid-1990s, about a dozen states used the 1115a waiver process to add new eligibility groups not recognized under federal law, such as childless adults, and/or to enroll beneficiaries into managed systems of care.

More recently, a number of states, including Florida, Massachusetts, Utah and Vermont, have used the Section 1115a authority to “de-couple” their programs from traditional Medicaid and enact more sweeping reforms. For example, Florida has taken the first steps toward converting its program from the standard “defined benefit” structure, under which enrollees are entitled to receive a set of services with no set dollar limit, to a “defined contribution” plan, where enrollees will have a pre-established budget (akin to a Health Savings Account) at their disposal to pay for medically necessary services. Florida’s model, and some of the recently-enacted programs in other states, seeks to encourage personal responsibility among beneficiaries, while locking-in greater budgetary controls for the state.

Alaska Medicaid Eligibility

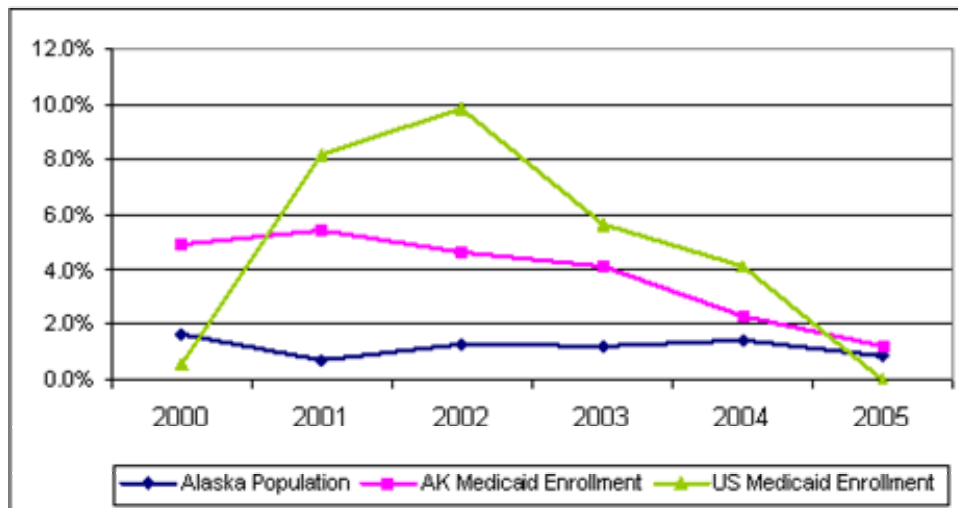
The Alaska Medicaid program has experienced substantial growth over the last ten years. Some of this growth has occurred as the result of state actions taken to expand coverage to additional categorically-needy optional groups, but a portion is attributable to broader demographic trends – a growing population overall and an elderly segment that is growing even faster.

From 2000 to 2003, Alaska’s annual enrollment growth hovered within a four to six percent range, higher than the state’s overall population growth rate of about one percent each year,

⁸ Section 1115a waiver authority differs from the waiver authority – known as “1915c” – used to establish most home- and community-based services (HCBS) programs for the elderly, physically disabled and developmentally disabled. The 1915c authority provides states with the ability to add an optional coverage group (see Exhibit 2-1) and define a new service setting or settings, but only within parameters already defined in regulations, and only for long-term care eligibles. Alaska’s Children with Complex Medical Conditions (CCMC) program is an example of a Section 1915c waiver.

but for most of that time below the national enrollment trend. More recently, as the economy has improved nationally and in Alaska, all three trend lines have converged (see Exhibit 2-2 below).

Exhibit 2-2 – Population & Medicaid Enrollment Trends (1995 – 2005)

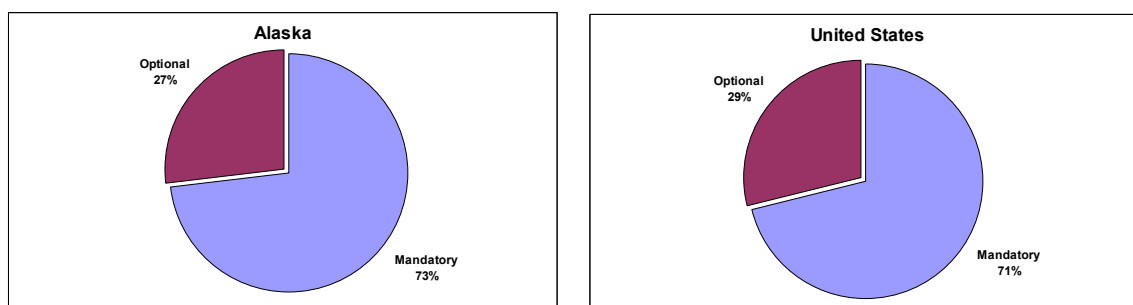


Sources: US Census Bureau, Current Population Survey data and DHSS Fiscal Year 2007 Budget Overview

Alaska Medicaid – Who is Covered?

Medicaid today provides health coverage to nearly one-in-five Alaskans, including one-in-three of the state's children. About 70 percent of Alaska Medicaid enrollees in state fiscal year 2005 belonged to one of the mandatory coverage groups, nearly the same portion as for the program nationally, as shown in Exhibit 2-3 below.⁹

Exhibit 2-3 – Mandatory & Optional Medicaid Enrollees – Alaska & US (2005)

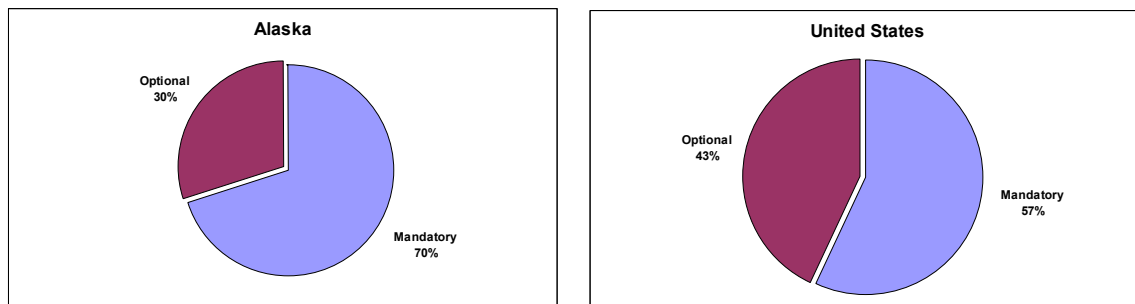


Sources: Centers for Medicare and Medicaid Services and DHSS FMS Medicaid Budget Unit

⁹ US data is for 2001

The optional-coverage group accounted for a relatively larger percentage of total Alaska Medicaid expenditures in 2005 – approximately 30 percent – but this was far below the percentage spent on optional enrollees nationally (see Exhibit 2-4 below). The difference is mainly attributable to the make-up of Alaska’s optional groups versus the composition of these groups nationally.

Exhibit 2-4 – Expenditures for Mandatory & Optional Medicaid Enrollees – Alaska & US (2005)



Sources: Centers for Medicare and Medicaid Services and DHSS FMS Medicaid Budget Unit

Alaska has a smaller elderly population, and relatively fewer long-term care enrollees, than most other states. The long-term care population is by far the most expensive Medicaid enrollment group, giving Alaska a relative advantage over other states, in terms of expenditures for its optional coverage groups. However, Alaska’s elderly population is increasing rapidly and in coming years the state will more closely resemble the rest of the country. This transformation has major implications for the program’s sustainability, as discussed later in the report.

Each state defines and categorizes its Medicaid population in regulation, often placing state-specific labels on the various mandatory and optional groups and subgroups. Alaska’s major optional-coverage categories¹⁰ are presented in Exhibit 2-5 on the next page. (These categories can be rolled up into the major coverage groups, such as “children”, as illustrated in the exhibit.) The optional coverage group enrollment and expenditure figures presented are for state fiscal year 2005.

¹⁰ Some individual group “line items”, such as Denali KidCare beneficiaries below 150 percent of FPL and above 150 percent are combined on the table. Two groups recognized in Alaska’s state Medicaid plan, but with no enrollment are not shown. The groups are children in ICFs/MR and children in Skilled Nursing Facilities.

Exhibit 2-5 – Alaska Medicaid Eligibility Categories

Optional Coverage Groups					
Group	Enrollment		Expenditures		
	Enrollees	Percent of Total Enrollment	Expenditures	Percent of Total Expenditures	Expenditures per Enrollee
Children (non-disabled)					
Title XIX Kids/Title XXI Kids (Denali Kid Care) – Children in households with income above mandatory limits, up to 175% of FPL	20,703	15.8%	\$43,773,909	4.3%	\$2,114
Kids in Custody – Foster care children and children in voluntary or court-ordered custody of the state	2,097	1.6%	\$22,833,156	2.2%	\$10,888
Pregnant Women					
Pregnancy/Post Partum – Pregnant women whose household income is between 133 and 175% of FPL	976	0.8%	\$1,919,098	0.2%	\$1,966
Aged, Blind & Disabled					
Optional Adult Public Assistance – Persons above SSI cash income limit up to 100% of FPL (non-LTC)	8,564	6.5%	\$129,883,255	12.7%	15,166
LTC Non-Cash – Persons above SSI cash income limit residing in Nursing Facility or enrolled in HCBS waiver program	1,782	1.4%	\$95,369,536	9.3%	\$53,518
Disabled Children					
TEFRA Children – Disabled children at home not receiving SSI and enrolled under federal TEFRA option	423	0.3%	\$4,843,210	0.5%	\$11,450
Subsidized Adoption – Children with special needs	288	0.2%	\$2,075,375	0.2%	\$7,206
BCC Women					
Women eligible due to diagnosis of breast or cervical cancer	171	0.1%	\$1,932,435	0.2%	\$11,301
Working Disabled					
Working disabled persons with incomes in excess of 250% of FPL	401	0.3%	\$3,336,161	0.3%	\$8,320
<i>Subtotal – All Optional</i>	<i>35,405</i>	<i>27.0%</i>	<i>\$305,966,135</i>	<i>29.9%</i>	<i>\$8,642</i>
<i>All Mandatory</i>	<i>95,731</i>	<i>73.0%</i>	<i>\$718,951,865</i>	<i>70.1%</i>	<i>\$7,510</i>
Grand Total – Medicaid	131,136	100.0%	\$1,024,918,000	100.0%	\$7,816

Sources: Centers for Medicare and Medicaid Services (2005); Alaska DHSS, FMS, and Medicaid Budget Unit

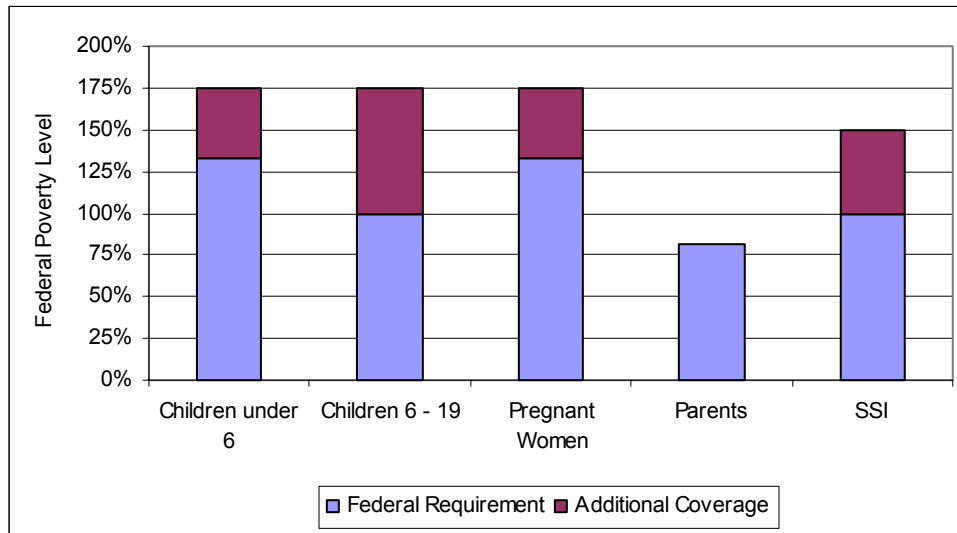
Note: Alaska does not cover parents above the federally-mandated income level

50-State Eligibility Analysis: How Does Alaska Compare?

Medicaid Eligibility Standards

Alaska can most readily be compared to the other 49 states and District of Columbia by examining income standards for the major categorically needy optional Medicaid groups. Exhibit 2-6 below summarizes Alaska's income limits across the five groups.

Exhibit 2-6 – Alaska Income Standards by Enrollment Group



When compared to the 49 other states and the District of Columbia, Alaska generally ranks somewhere in the middle. Exhibits 2-7 and 2-8 on the following two pages provide the maximum income in the other states and the District of Columbia for children and pregnant women/parents, respectively.

As the exhibits show, Alaska:

- Ranks between 17th and 36th highest in covering children, depending on the age cohort
- Ranks 36th highest in covering low-income pregnant women
- Ranks between 18th and 24th highest in covering parents (depending on their employment status)

Although Alaska does not have overly generous eligibility standards – as compared to the other 50 programs – the state does have a higher than average portion of the population enrolled into Medicaid. The next section explores why.

Exhibit 2-7 – State FPL Limits for Children

	Alaska & United States			
	Under One Year	Ages 1 – 5	Ages 6 – 19	Separate SCHIP Limit
US Requirement	133%	133%	100%	100%
Highest State	300%	300%	300%	350%
Lowest State	133%	133%	100%	140%
Alaska	175%	175%	175%	175%
Alaska Rank	36th	19th	17th	35th

Individual State FPL Limits for Children by Age				Separate SCHIP Limit
State	Under One Year	Ages 1 – 5	Ages 6 – 19	
Alabama	133%	133%	100%	200%
Alaska	175%	175%	175%	175%
Arizona	140%	133%	100%	200%
Arkansas	200%	200%	200%	N/A
California	200%	133%	100%	250%
Colorado	133%	133%	100%	200%
Connecticut	185%	185%	185%	300%
Delaware	200%	133%	100%	200%
District of Columbia	200%	200%	200%	N/A
Florida	200%	133%	100%	200%
Georgia	200%	133%	100%	235%
Hawaii	200%	200%	200%	N/A
Idaho	150%	150%	150%	185%
Illinois	200%	133%	133%	200%
Indiana	150%	150%	150%	200%
Iowa	200%	133%	133%	200%
Kansas	150%	133%	100%	200%
Kentucky	185%	150%	150%	200%
Louisiana	200%	200%	200%	N/A
Maine	200%	150%	150%	200%
Maryland	200%	200%	200%	300%
Massachusetts	200%	150%	150%	200%
Michigan	185%	150%	150%	200%
Minnesota	280%	275%	275%	N/A
Mississippi	185%	133%	100%	200%
Missouri	300%	300%	300%	N/A
Montana	133%	133%	100%	150%
Nebraska	185%	185%	185%	N/A
Nevada	133%	133%	100%	200%
New Hampshire	300%	185%	185%	300%
New Jersey	200%	133%	133%	350%
New Mexico	235%	235%	235%	N/A
New York	200%	133%	100%	250%
North Carolina	200%	200%	100%	200%
North Dakota	133%	133%	100%	140%
Ohio	200%	200%	200%	N/A
Oklahoma	185%	185%	185%	N/A
Oregon	133%	133%	100%	185%
Pennsylvania	185%	133%	100%	200%
Rhode Island	250%	250%	250%	N/A
South Carolina	185%	150%	150%	N/A
South Dakota	140%	140%	140%	200%
Tennessee	185%	133%	100%	N/A
Texas	185%	133%	100%	200%
Utah	133%	133%	100%	200%
Vermont	300%	300%	300%	300%
Virginia	133%	133%	133%	200%
Washington	200%	200%	200%	250%
West Virginia	150%	133%	100%	200%
Wisconsin	185%	185%	185%	N/A
Wyoming	133%	133%	100%	200%

Source: StateHealthFacts.org

Exhibit 2-8 – State FPL Limits for Adults

	Alaska & United States		
	Pregnant Women	Non-Working Parents	Working Parents
US Requirement	133%	N/A	N/A
Highest State	275%	275%	275%
Lowest State	133%	12%	19%
Alaska	175%	75%	81%
Alaska Rank	36 th	18 th	24 th

State	Pregnant Women	Non-Working Parents	Working Parents
Alabama	133%	12%	19%
Alaska	175%	75%	81%
Arizona	175%	200%	200%
Arkansas	133%	15%	19%
California	200%	100%	107%
Colorado	200%	31%	38%
Connecticut	185%	150%	157%
Delaware	200%	100%	107%
District of Columbia	200%	200%	200%
Florida	185%	23%	60%
Georgia	200%	32%	56%
Hawaii	185%	100%	100%
Idaho	133%	24%	30%
Illinois	200%	185%	192%
Indiana	150%	21%	28%
Iowa	200%	32%	79%
Kansas	150%	30%	37%
Kentucky	185%	39%	68%
Louisiana	200%	13%	20%
Maine	200%	150%	157%
Maryland	250%	32%	39%
Massachusetts	200%	133%	133%
Michigan	185%	34%	58%
Minnesota	275%	275%	275%
Mississippi	185%	27%	34%
Missouri	185%	22%	42%
Montana	133%	37%	64%
Nebraska	185%	48%	60%
Nevada	133%	26%	84%
New Hampshire	185%	47%	58%
New Jersey	200%	100%	100%
New Mexico	185%	29%	67%
New York	200%	150%	150%
North Carolina	185%	41%	56%
North Dakota	133%	39%	67%
Ohio	150%	90%	90%
Oklahoma	185%	35%	44%
Oregon	185%	100%	100%
Pennsylvania	185%	31%	63%
Rhode Island	250%	185%	192%
South Carolina	185%	49%	97%
South Dakota	133%	59%	59%
Tennessee	185%	70%	81%
Texas	185%	14%	30%
Utah	133%	43%	50%
Vermont	200%	185%	192%
Virginia	150%	24%	31%
Washington	185%	41%	81%
West Virginia	150%	19%	37%
Wisconsin	185%	185%	192%
Wyoming	133%	44%	59%

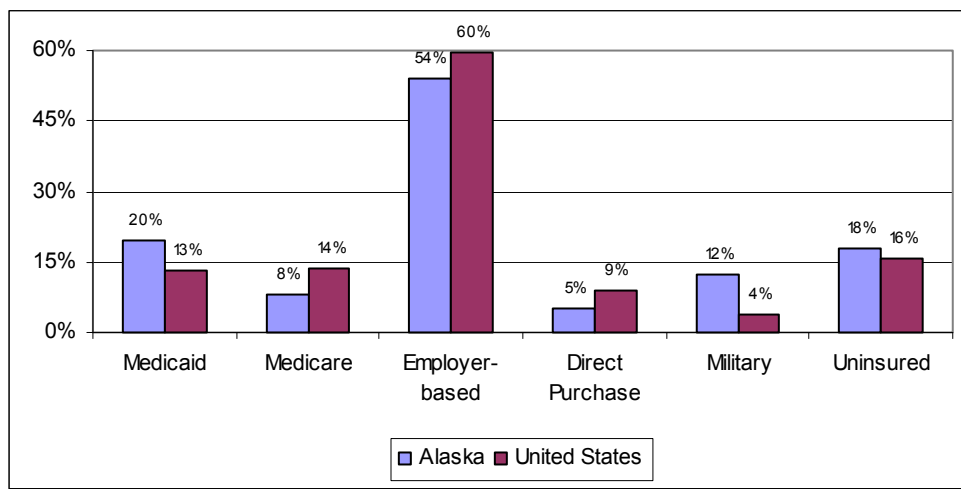
Source: StateHealthFacts.org

Medicaid Enrollment & Other Payers

In 2005, Medicaid provided health coverage to over 38 million Americans, or about 13 percent of the US population. During the same year, enrollment in Alaska stood at 131,000 persons out of a population of 664,000, or nearly 20 percent of the state's residents.¹¹

Alaska looks different from the rest of the country across other payer groups as well. Overall, Medicaid is the second largest payer in the state, while it is the third largest nationally (see exhibit 2-9). Medicare, which is the number two payer in the rest of the country, plays a smaller role in Alaska, reflecting the state's historically small elderly population (12.4 percent of the population nationally is age 65 or older, versus 6.4 percent in Alaska).

Exhibit 2-9 – Health Coverage by Payer Type- Alaska versus US Total (2005)¹²



Source: US Census Bureau, Current Population Survey

¹¹ Sources: US Census Bureau, Current Population Survey and FY 2007 DHSS Budget Overview

¹² Numbers add to more than 100%, as persons falling into multiple categories in a year are recorded within each category. The Current Population Survey (CPS) develops estimates by extrapolating data collected through telephone surveys. The CPS for 2005 reported a Medicaid enrollment in Alaska of 16 percent, subject to a margin of error. The CPS figure has been replaced with DHSS actual numbers and other payer categories have been prorated to allow for the higher Medicaid figure while maintaining their relative relationship in size to each other.

Other notable characteristics of Alaska's health insurance market:

- Only about 60 percent of Alaskans had some type of private insurance (employer-based + directly purchased) in 2005, versus nearly 68 percent for the country as a whole. This is unsurprising, since there is a strong correlation between an employer's size and whether it offers health coverage, and Alaskans are more likely than residents of other states to work for a small employer. In 2001, 44 percent of Alaskans in the workforce were employed by firms with fewer than 100 workers, versus 35 percent of the workforce nationally.¹³ Alaskans also have fewer insurance options to choose from than residents of more populous states.
- TRICARE, the military's health insurance system, covers a larger portion of the population in Alaska than in any other state
- A somewhat higher percentage of Alaskans – close to one-in-five – lacked health insurance for the entirety of 2005. The average for the country as a whole was closer to one-in-six. (The uninsured, as reported by the federal government, includes Native Alaskans and other Native Americans who rely solely on tribal health providers and the IHS for their health care.)

Overall, Alaska ranked in the top ten states both in terms of the percentage of the population with Medicaid coverage and the percentage uninsured. Alaska is one of three states – the other two being Arizona and New Mexico – to appear at the top of both lists as shown in Exhibit 2-10.

¹³ Source: *US Small Business Administration*

Exhibit 2-10 – Medicaid & Uninsured – Top & Bottom States

See full list of
states on next
page – Exhibit 2-
11

Percent with Medicaid		
Rank	State	Percent
1	District of Columbia	21.9%
2	Mississippi	21.1%
3	Vermont	19.9%
4	Alaska	19.7%
5	Maine	19.6%
6	New York	18.4%
7	Rhode Island	17.2%
8	New Mexico	17.0%
9	Tennessee	16.4%
10	Arizona	16.1%
(tie)	Alabama	16.1%

Percent Uninsured		
Rank	State	Percent
1	Texas	24.2%
2	Florida	20.7%
3	New Mexico	20.4%
4	Arizona	20.2%
5	California	19.4%
6	Georgia	18.9%
7	Louisiana	18.8%
8	Oklahoma	18.5%
9	West Virginia	17.9%
10	Alaska	17.8%
(tie)	Arkansas	17.8%

Source: US Census Bureau, Current Population Survey (2005)

Alaska appears on the list of top Medicaid states for different reasons than the others. Four of the top ten states – Mississippi, Maine, New Mexico and Alabama – plus the District of Columbia, have relatively large populations living near or below the poverty line. The remaining five used the Medicaid Section 1115a research and demonstration waiver option in the 1980s and 1990s to extend coverage to large numbers of persons who do not meet the traditional federal standards and who previously had been uninsured (Tennessee actually falls into both categories).

Exhibit 2-11 – Payer Mix by State

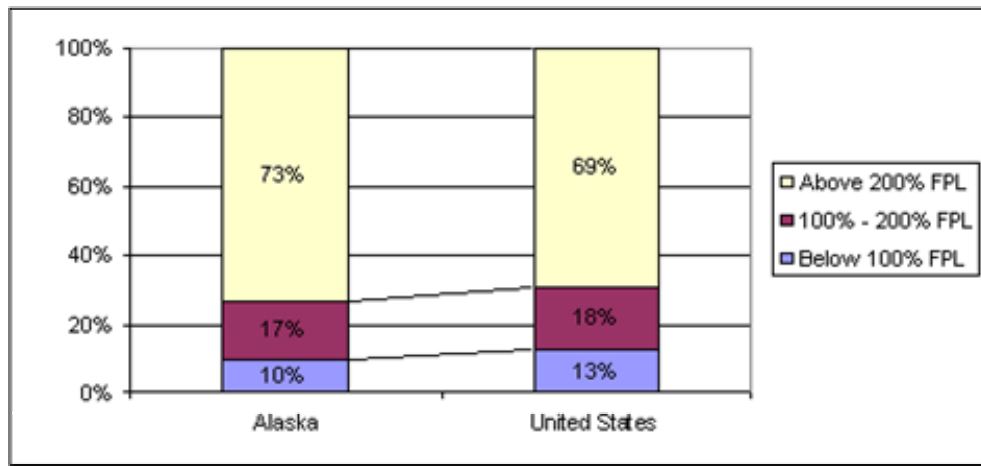
	Alaska & United States					
	Medicaid	Medicare	Private Insurance		Military	Uninsured
			Employer-Sponsored	Direct Purchase		
United States	13%	14%	60%	9%	4%	16%
Highest State	22%	19%	70%	19%	12%	24%
Lowest State	6%	8%	49%	0%	0%	8%
Alaska	20%	8%	56%	5%	12%	18%
Alaska Rank	4th	51st	43rd	51st	1st	12th

Individual State Results (2003/2004 two-year average)						
State	Medicaid	Medicare	Employer	Direct Purchase	Military	Uninsured
Alabama	16%	16%	59%	7%	5%	15%
Alaska	20%	8%	54%	5%	12%	18%
Arizona	16%	14%	53%	7%	4%	20%
Arkansas	14%	15%	52%	10%	6%	18%
California	16%	12%	53%	10%	3%	19%
Colorado	8%	10%	62%	10%	5%	17%
Connecticut	10%	15%	68%	11%	2%	11%
Delaware	11%	16%	66%	6%	0%	13%
District of Columbia	22%	12%	55%	8%	2%	14%
Florida	11%	17%	53%	11%	6%	21%
Georgia	13%	11%	56%	7%	5%	19%
Hawaii	10%	14%	68%	8%	11%	9%
Idaho	12%	12%	60%	12%	3%	15%
Illinois	11%	13%	65%	8%	2%	14%
Indiana	12%	12%	63%	9%	3%	14%
Iowa	11%	14%	67%	14%	4%	9%
Kansas	10%	15%	64%	14%	5%	11%
Kentucky	15%	16%	63%	7%	4%	13%
Louisiana	14%	16%	55%	9%	3%	19%
Maine	20%	16%	58%	9%	6%	11%
Maryland	9%	13%	66%	8%	5%	14%
Massachusetts	14%	14%	67%	7%	2%	10%
Michigan	14%	13%	67%	7%	2%	11%
Minnesota	9%	14%	68%	12%	2%	8%
Mississippi	21%	16%	49%	9%	5%	17%
Missouri	13%	15%	62%	12%	3%	12%
Montana	11%	17%	51%	14%	6%	17%
Nebraska	10%	14%	63%	13%	6%	12%
Nevada	8%	14%	62%	7%	6%	17%
New Hampshire	6%	14%	70%	10%	4%	10%
New Jersey	8%	13%	68%	7%	2%	15%
New Mexico	17%	15%	51%	6%	6%	20%
New York	18%	15%	60%	8%	1%	13%
North Carolina	13%	14%	57%	10%	5%	16%
North Dakota	8%	15%	61%	16%	6%	12%
Ohio	12%	14%	66%	0%	2%	12%
Oklahoma	14%	16%	55%	8%	7%	18%
Oregon	13%	14%	58%	12%	3%	16%
Pennsylvania	12%	16%	65%	11%	2%	10%
Rhode Island	17%	14%	64%	7%	3%	12%
South Carolina	14%	16%	57%	7%	4%	18%
South Dakota	11%	15%	56%	19%	7%	12%
Tennessee	16%	15%	55%	9%	6%	14%
Texas	12%	12%	52%	7%	4%	24%
Utah	11%	9%	62%	9%	3%	17%
Vermont	20%	14%	60%	9%	4%	12%
Virginia	8%	12%	65%	9%	10%	14%
Washington	10%	12%	62%	10%	7%	14%
West Virginia	14%	19%	58%	6%	5%	18%
Wisconsin	12%	14%	67%	12%	2%	10%
Wyoming	11%	14%	56%	14%	7%	16%

Source: US Census Bureau Current Population Survey (2005)

Alaska belongs to neither group. The state has not sought waiver authority to extend Medicaid coverage beyond the mandatory and optional populations recognized in federal statute. The state also does not have a larger than average low-income population. In 2005, about ten percent of Alaskans lived in households with incomes below the federal poverty level, compared to 12.6 percent nationally.¹⁴ Another 17 percent of Alaskans lived in households between 100 and 200 percent of poverty, almost identical to the national percentage. (See Exhibit 2-12 below.)

Exhibit 2-12 – Percent Living Below or Near Poverty – Alaska & US (2005)



Source: US Census Bureau, Current Population Survey (2004-2005 two-year average)

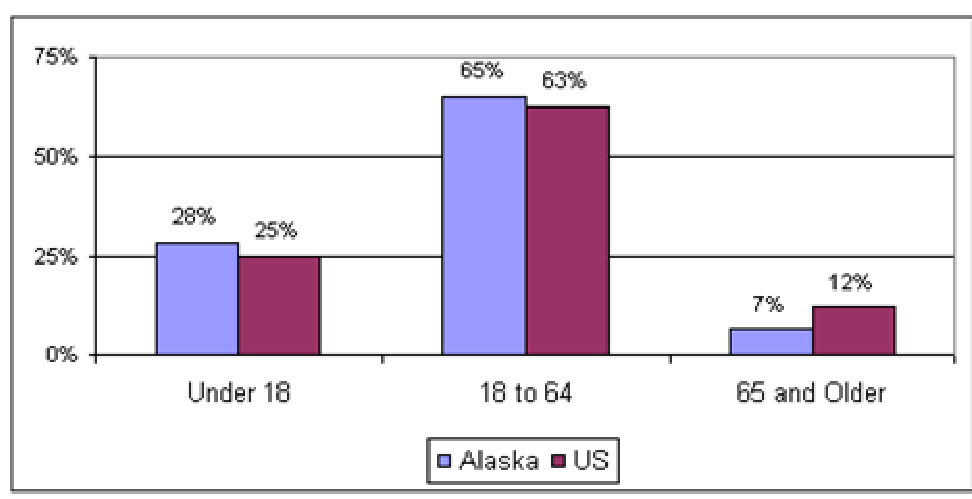
Instead, Alaska's relatively large Medicaid population is driven primarily by the state's demographics. Most Medicaid beneficiaries nationally are children and pregnant women, and Alaska has higher than average numbers of both groups.

Twenty-eight percent of the state's residents in 2005 were below the age of 18, versus 25 percent nationally.¹⁵ (See Exhibit 2-13 on the next page.) And Alaska's birth rate, at 15.8 births per 1,000 in 2004, exceeded the US average of 14.0 and was surpassed only by Utah, Texas, Arizona and Idaho.

¹⁴ Alaska and Hawaii have state-specific federal poverty level (FPL) thresholds, while the other 48 states share a common threshold. In 2006, 100 percent of the FPL in Alaska for a single individual equaled \$12,250, versus \$11,270 in Hawaii and \$9,800 in the rest of the country.

¹⁵ Source: StateHealthFacts.org

Exhibit 2-13 – Population by Age Cohort: Alaska & United States (2005)



Source: US Census Bureau, Current Population Survey (2005)

Looking ahead, the Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005 – 2025, released earlier this year by The Lewin Group and ECONorthwest, projects a slowdown in enrollment growth among children and pregnant women. At the same time, the report warns that Alaska’s elderly population overall, and its presence within Medicaid, will increase substantially in coming years. This has significant implications for the long-term care component of Medicaid, and the program’s fiscal soundness, as discussed later in the chapter.

Uninsured Alaskans & Medically Needy Option

Demographics also contribute to Alaska’s significant number of uninsured. The elderly, the great majority of whom qualify for Medicare, are underrepresented in the state. When only persons below the age of 65 are considered, Alaska drops to fifteenth place, still higher than the national average, but not by a substantial margin (18.8 percent versus 17.9 percent¹⁶).

Alaska also has a greater number of Native Americans than any other state. While many Native Alaskans are enrolled in Medicaid or covered through a private payer, a portion of this population relies solely on tribal or IHS providers for their health coverage. From the federal government’s perspective, these persons are uninsured.

¹⁶ *Source: US Census Bureau, Current Population Survey (2005)*

Finally, Alaska's Medicaid program as currently structured does not include a medically needy category. The absence of this category may also be contributing to the number of uninsured.

As previously discussed, states have the option to establish "medically-needy" programs to serve persons whose income (and/or resources) exceeds the categorically needy limits, but who incur medical expenses sufficient to qualify for Medicaid on that basis. Medically-needy programs allow such individuals to use incurred/unpaid medical bills to "spend down" the difference between their income and the income limit to become eligible. People with higher incomes qualify if they have medical bills equal to or greater than the amount by which their income exceeds the Medically-Needy Income Levels. The benefits offered within the medically-needy category also do not have to be as extensive as what is offered to the categorically-needy.

Thirty-four states and the District of Columbia operate medically-needy programs; Alaska and 15 other states do not.¹⁷ Among the states – including Alaska – that lack such programs, the uninsured rate runs an average of about three percent higher than in the "medically-needy" states.¹⁸

The Department of Health and Social Services (DHSS) does operate a state-funded program, known as Chronic and Acute Medical Assistance, or CAMA, which serves as a payer of last resort for individuals who meet program eligibility standards (e.g., maximum monthly household income of \$300 for one person or \$400 for two people, and less than \$500 in countable resources) and have a qualifying medical condition.

The qualifying medical conditions for CAMA are:

- Terminal illness
- Cancer requiring chemotherapy
- Chronic diabetes or diabetes insipidus
- Chronic seizure disorders
- Chronic mental illness
- Chronic hypertension

A segment of the CAMA target population likely consists of persons awaiting SSI determination by the federal government, and subsequent qualification for Medicaid under the SSI category. Alaska's qualifying conditions overall are consistent with the types of

¹⁷ The other 15 states are: Alabama, Arizona, Colorado, Delaware, Idaho, Indiana, Missouri, Nevada, New Mexico, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Texas

¹⁸ Differential calculated using 2005 CPS data

conditions covered in the medically needy programs in other states, though often these programs are also open to persons with catastrophic medical expenses.

States are not limited to covering the medically-needy population solely through expansion of their traditional Medicaid programs and creation of a new “entitled” group. As an alternative, states can seek Section 1115a research and demonstration waiver authority to cover targeted populations, and receive federal matching dollars. One advantage of the waiver approach is that a state, with federal approval, can place an enrollment and/or expenditure cap on the new program, thereby limiting its fiscal commitment.

For example, Mississippi in 2005 received approval for a waiver to extend coverage to chronically ill individuals with incomes up to 135 percent of the federal poverty level not eligible for Medicare. The covered conditions are identical to those on the CAMA list, with the addition of persons in kidney failure and the exclusion of the terminally ill.

Waiver programs must be designed to be budget neutral to the federal government. Mississippi met this condition by demonstrating that enrollment of these individuals into Medicaid today would forestall their eventual need for costlier Medicaid long-term care services.

In state fiscal year 2004, the CAMA program served 1,522 persons. Program expenditures totaled \$2.2 million, of which about three-quarters went for prescription drugs and most of the remainder for hospital and physician services. If this group was enrolled under a research and demonstration waiver – either for a pharmacy-only benefit or for all services – the state expenditures could be used to draw down funds to serve additional persons. Alternately, the federal matching funds could be used to reduce state expenditures by about \$1.3 million (at the current federal matching rate).

Other “Unmatched” Populations

Alaska funds services for two other high cost groups with state-only dollars to a greater extent than other states. They are: persons with developmental disabilities and persons with behavioral health needs. Opportunities for obtaining additional federal funds for these two populations are addressed in the Covered Services chapter.

Eligibility Trends

The Lewin Group/ECONorthwest long-term forecast for Medicaid projects that over the next ten years, the elderly – who today are the smallest contingent in Medicaid (after children and working-age adults) will become the largest.¹⁹ As that report notes, and the next chapter in this report illustrates, the disabled and elderly enrolled in long-term care are the costliest groups within Medicaid. As their numbers increase, program expenditure growth will also accelerate.

The state does have some ability to control these costs on the eligibility side, but actions should be targeted in a manner that does not yield unintended consequences in the form of a cost shift to providers. For example, Alaska could reduce or eliminate the optional coverage categories for children, but this is the state's least costly group, on a per eligible basis, and in coming years will represent a smaller portion of total expenditures.

Moving children, or any other optional group, to the ranks of the uninsured also means shifting at least a portion of their medical expenses – more than half of which today are reimbursed by the federal government – to providers in the form of uncompensated care and/or to the state-funded CAMA program. In fact, the state's best alternative for reducing expenditures among non-long-term care enrollees would be to expand the program by moving the CAMA group onto Medicaid, potentially in a capped Section 1115a program, and claim federal matching dollars for what today is a state-funded program.

The long-term care population poses a different set of challenges. The state is mandated to cover nursing home residents but has the option to reduce or eliminate HCBS waiver slots. The elimination of waiver slots for persons who truly require long-term care, however, means placement in a costly nursing home bed.

The state does have the ability, though, through a well-structured clinical assessment process, to control who qualifies for long-term care – regardless of placement – and ensure that only those who meet the federal standard of need are enrolled into the program. DHSS has taken the first step in this regard through adoption of prior authorization requirements for the Personal Care Attendant program. Development of a comprehensive screening instrument and process across all long-term care would complete the process. (See the Long-Term Care section of Chapter 3 for a further discussion of this topic.)

¹⁹ *The Lewin Group, Inc. and ECONorthwest Long-Term Forecast, page ii.*

Eligibility – Findings & Recommendations

Alaska's eligibility standards place it in the middle tier of states, in terms of the optional coverage groups included in the Medicaid program. Historically, the program has been heavily tilted toward children and pregnant women, and away from the more costly disabled and elderly long-term care populations.

That is about to change. Over the next ten years, the program will take on a new, costlier profile. To a large extent, the growth will occur within the mandatory coverage groups, but the state will have the ability to exert some control if a comprehensive screening mechanism for long-term care is put in place.

At the same time, Alaska should give consideration to expanding the program by bringing into it several groups currently being served with state-only dollars. These groups – CAMA, certain developmentally disabled individuals and seriously mentally ill adults – could be enrolled under a waiver with carefully defined benefits and an expenditure cap. The net result for the state would either be the opportunity to offer improved access to services at the same cost (in state dollars) or to maintain current service levels while shifting the majority of the financial burden to the federal government.

CHAPTER 3 – COVERED SERVICES

Key Findings

- ✓ Alaska is comparable to other states in terms of the optional Medicaid services it offers
- ✓ Alaska's program is expensive, as compared to the other states. Adjusting for cost of living differences, Alaska spent \$1,200 more per enrollee than the national average, in 2003
- ✓ Program expenditure growth, which was at double-digit levels in the first part of the decade, has abated but is expected to accelerate again before the decade is out
- ✓ DHSS has taken a number of steps to contain costs, consistent with actions in other states
- ✓ There are further opportunities to rein in costs in selected program areas, particularly pharmacy and long-term care
- ✓ The state also has the opportunity to secure more federal funds for long-term care services paid for today with state-only dollars
- ✓ The state also could gain control over service costs – and obtain more operational flexibility – by replacing the traditional Medicaid program with a Section 1115a research and demonstration program, as outlined in Chapter 6

Introduction

This chapter examines the services offered through Alaska Medicaid, both mandatory and optional, and compares Alaska's program to the 49 other states. Expenditure and service utilization data is presented for the program overall and for five major categories of service: acute care, long-term care, pharmacy, developmental services and behavioral health. (The tribal health care system, which includes all of these service categories, is discussed as a stand-alone section in the next chapter.) DHSS administrative processes and regulations also are reviewed. The chapter concludes with a brief summary of findings and a discussion of potential reforms. (Full recommendations are presented in Chapter 6.)

Mandatory & Optional Services

State Medicaid programs must make available a federally-defined package of “mandatory services” to categorically-needy beneficiaries (the only type enrolled in Alaska Medicaid) and may, at their choosing, supplement the mandatory services with one or more federally-recognized “optional services”.

The list of mandatory services includes:

- Inpatient hospital services
- Outpatient hospital services
- Physician services
- Laboratory and x-ray services
- Prenatal care
- Vaccines for children
- Nursing facility services for persons aged 21 or older
- Family planning services and supplies
- Rural health clinic services
- Home health care for persons eligible for skilled-nursing services
- Pediatric and family nurse practitioner services.
- Nurse-midwife services
- Federally-Qualified Health Center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings
- Early and periodic screening, diagnostic and treatment (EPSDT) services for children under age 21

The concept of mandatory versus optional services is more meaningful for adults than children. While states may exclude optional services from their adult benefit list, and may also place limits, or caps, on individual service units for adults (e.g., five prescriptions per month), children are shielded from such action. Under the federal Early and Periodic

Screening, Diagnosis and Treatment (EPSDT) component of Medicaid, children must be provided with medically necessary services to “correct or ameliorate defects and physical and mental illnesses or conditions discovered by EPSDT screening services”, even if these services are not covered under the state Medicaid plan. Similarly, states cannot place limits, or caps, on the number of service units.

With this caveat in mind, Exhibit 3-1 on the following page summarizes the federally-optional service types. Acute and long-term care services are shown separately. The exhibit also identifies the services offered by Alaska Medicaid and other states and District of Columbia, and presents data on the number of recipients and total expenditures for each service in state fiscal year 2005.²⁰

²⁰ *The number of states offering each service is partly determined by allowable billing practices within each state. For example, while only 34 states permit Psychologists to directly bill Medicaid for their services, the remaining states cover this service indirectly, through Community Mental Health Centers.*

Exhibit 3-1 – Optional Medicaid Services (2005)²¹

Optional Services	Total States Covering	Alaska (Services with no data are not covered)		
		Recipients	Net Expenditures	Percent of Total Expenditures
Acute Care				
Chiropractors	27	275	\$35,700	0.0%
Christian Science Sanatoria	12			
Critical Access Hospitals	25			
Dental (Adult)	44	4,426	\$2,171,900	0.2%
Dentures	35			
Diagnostic Services	33			
Durable Medical Equipment/Supplies	51	7,518	\$8,691,700	0.8%
Emergency Hospital Services in non-Medicare Facilities	35	---	---	0.0%
Eyeglasses	43			
Hospice Care	48			
Mental Health Rehabilitation/ Stabilization – Rehab	46	3,111	\$18,074,100	1.8%
Nurse Anesthetist	31			
Occupational Therapy	40	132	\$138,900	0.0%
Optometry and Eyeglasses	49	9,109	\$1,108,600	0.1%
Physical Therapy	49	1,648	\$1,405,800	0.1%
Physician Directed Clinic Services	49	4,724	\$19,022,500	1.9%
Podiatrists	44			
Prescription Drugs	51	28,156	\$99,144,800	9.7%
Preventive Services for Adults	36			
Primary Care Case Management	25			
Private Duty Nursing	27			
Prosthetic Services	49	8,000	\$584,700	0.1%
Psychologists	34	23	\$26,600	0.0%
Respiratory Care for the Ventilator-Dependent	16			
Screening Services	33	2,502	\$139,900	0.0%
Speech and Language Therapy – Home Health	48			
Therapies for Speech, Hearing and Language Disorders	40	1,309	\$2,153,700	0.2%
Long-Term Care				
Hospice Care	48	21	\$72,200	0.0%
Inpatient Psychiatric Services – Under Age 21	46	6	\$158,900	0.0%
Institute for Mental Disease Services – Adults 65+	43			
ICF/MR	51	---	---	0.0%
Long-Term Care Waiver (HCBS)	51	2,959	\$79,204,300	7.7%
Personal Care	36	3,817	\$75,550,800	7.4%
Program of All-Inclusive Care for the Elderly (PACE)	22			
Targeted Case Management	48	---	---	0.0%
Subtotal – All Optional Services			\$307,685,100	30.0%
All Mandatory Services			\$717,232,900	70.0%
Grand Total – Medicaid			\$1,024,918,000	100.0%

Sources: Centers for Medicare and Medicaid Services (2005); Alaska DHSS, FMS, and Medicaid Budget Unit

²¹ Services with “0” recipients and dollars, such as ICF/MR, are covered under Alaska’s Medicaid state plan, but are not actually being delivered.

50-State Expenditure Analysis: How Does Alaska Compare?

Medical expenditures historically have increased at a faster rate than the general consumer price index. This has been true for both commercial health insurance and Medicaid.

In Alaska, aggregate expenditures for Medicaid services grew at a double digit pace in the first four years of the decade before slowing in state fiscal year 2005. While a portion of this increase was attributable to a growing caseload, much of the upward pressure was the result of more intensive service use by enrollees and underlying medical inflation, as illustrated by the per-enrollee annual growth rate shown in Exhibit 3-2.

Exhibit 3-2 – Alaska Medicaid Expenditures – SFY 2000 – 2006

SFY	Enrollees	Expend/ Enrollee	Expenditures by Fund Source (Thousands)				Annual Growth Rate	
			General	Federal	Other	Total	Total Dollars	Per Enrollee
2000	110,219	\$4,271	\$145,515	\$307,508	\$17,666	\$470,709		
2001	116,226	\$5,024	\$152,791	\$387,432	\$43,671	\$583,894	24.0%	17.6%
2002	121,582	\$5,939	\$177,701	\$497,428	\$46,926	\$722,055	23.7%	18.2%
2003	126,632	\$6,540	\$211,077	\$558,581	\$58,460	\$828,118	14.7%	10.1%
2004	129,528	\$7,500	\$230,119	\$658,741	\$82,631	\$971,491	17.3%	14.7%
2005	131,136	\$7,816	\$276,089	\$685,474	\$63,355	\$1,024,918	5.5%	4.2%
2006	137,693	\$7,706	\$278,880	\$702,835	\$79,479	\$1,061,114	3.5%	-1.4%

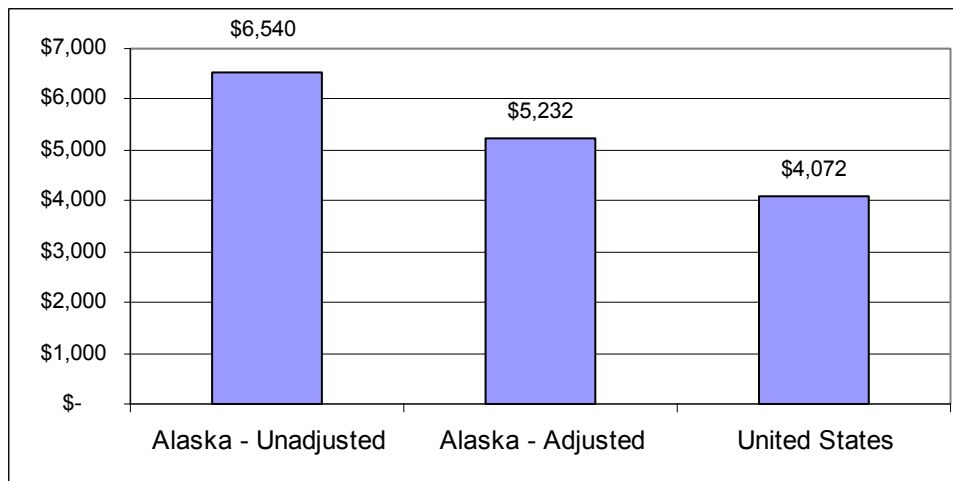
Source: DHSS 2006 and 2007 Budget Overviews

Note: 2000 – 2005 data is actual; 2006 recipient count is estimated based on average annual growth in preceding five years (5%); 2006 expenditures are Management Plan figures

In 2003, the most recent year for which such data is available nationally, average expenditures per enrollee in Alaska – unadjusted for differences in cost of living – were more than 50 percent higher than the US average, even though Alaska's Medicaid enrollment is dominated by children, who are less costly than adults (see Exhibit 3-3 on the next page).

A portion, but not all, of this gap was attributable to the state's higher cost of living. Adjusting for Alaska's higher living costs²² reduces the gap from \$2,500 to just under \$1,200 – still significantly higher than the national average.

Exhibit 3-3 – Average Cost per Enrollee – Alaska & US (2003)



Source: StateHealthFacts.Org

When compared to the other 49 states and District of Columbia, Alaska ranked third highest overall (in nominal dollars), behind New York and the District of Columbia. The state actually ranked highest for non-aged, non-disabled adults, and second highest for children and disabled persons, as illustrated in Exhibit 3-4 on the following page

²²The adjustment was made by calculating the ratio of income for a single person at 100 percent of the FPL nationally and in Alaska, and multiplying the average cost per enrollee in Alaska by this ratio.

Exhibit 3-4 – Medicaid Expenditures per Beneficiary by State (2003)

	Alaska & United States				
	Children	Adults	Elderly	Blind & Disabled	Total
United States	\$1,467	\$1,872	\$10,799	\$12,265	\$4,072
Highest State	\$3,961	\$4,443	\$21,903	\$24,888	\$7,583
Lowest State	\$912	\$813	\$5,054	\$5,623	\$2,520
Alaska	\$3,504	\$4,443	\$17,921	\$23,402	\$6,512
Alaska Rank	2nd	1st	5th	2nd	3rd

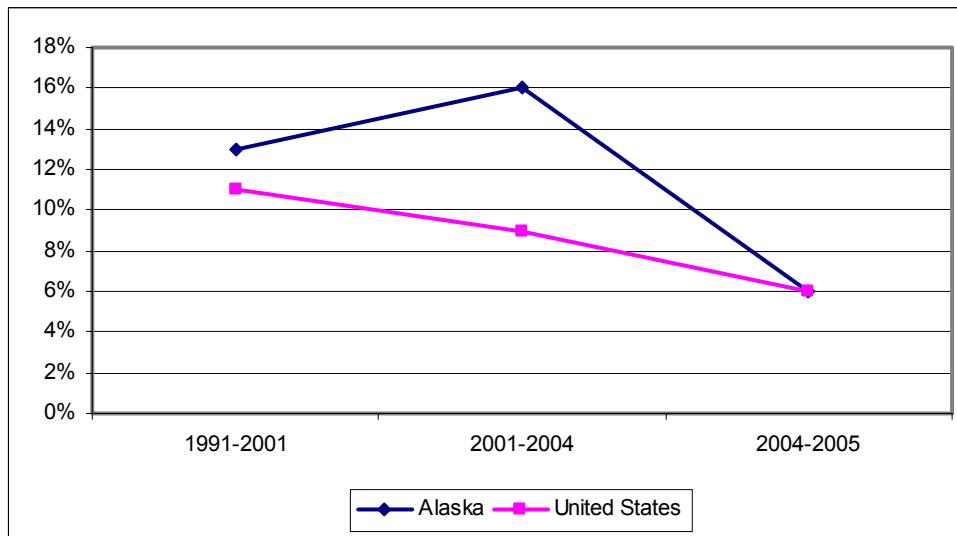
Individual State Medicaid Payments per Enrollee – FY2003					
State	Children	Adults	Elderly	Blind & Disabled	Total
Alabama	\$1,595	\$989	\$7,485	\$5,623	\$3,119
Alaska	\$3,504	\$4,443	\$17,921	\$23,402	\$6,512
Arizona	\$1,443	\$1,293	\$7,531	\$10,924	\$2,525
Arkansas	\$1,396	\$879	\$9,919	\$8,420	\$3,215
California	\$1,210	\$813	\$8,016	\$11,475	\$2,520
Colorado	\$1,603	\$2,447	\$12,290	\$13,932	\$4,595
Connecticut	\$1,920	\$2,281	\$20,158	\$21,050	\$6,657
Delaware	\$1,887	\$2,661	\$14,524	\$15,535	\$4,738
District of Columbia	\$2,775	\$3,255	\$18,038	\$19,176	\$7,020
Florida	\$1,160	\$1,696	\$8,986	\$9,938	\$3,621
Georgia	\$1,302	\$2,606	\$7,336	\$7,421	\$3,061
Hawaii	\$1,413	\$2,163	\$10,102	\$9,835	\$3,462
Idaho	\$1,220	\$2,698	\$14,368	\$14,759	\$4,119
Illinois	\$1,372	\$2,359	\$4,749	\$13,077	\$3,552
Indiana	\$1,402	\$2,206	\$12,360	\$12,843	\$4,087
Iowa	\$1,540	\$2,358	\$13,351	\$14,611	\$5,169
Kansas	\$1,499	\$2,058	\$14,027	\$13,823	\$4,856
Kentucky	\$1,844	\$2,651	\$9,526	\$7,878	\$4,339
Louisiana	\$3,961	\$2,572	\$7,671	\$9,100	\$3,236
Maine	\$3,961	\$3,606	\$5,054	\$9,155	\$5,445
Maryland	\$2,327	\$3,984	\$14,345	\$17,053	\$5,870 ³
Massachusetts	\$1,593	\$1,637	\$14,052	\$13,012	\$5,312
Michigan	\$1,033	\$1,993	\$11,601	\$10,446	\$3,741
Minnesota	\$2,254	\$2,440	\$13,977	\$21,583	\$6,376
Mississippi	\$1,225	\$2,664	\$8,142	\$7,132	\$3,495
Missouri	\$1,552	\$1,794	\$11,386	\$10,676	\$3,784
Montana	\$1,888	\$2,858	\$13,591	\$10,942	\$4,664
Nebraska	\$1,768	\$2,222	\$15,166	\$13,382	\$4,344
Nevada	\$1,409	\$2,059	\$7,336	\$11,033	\$3,491
New Hampshire	\$2,292	\$2,606	\$17,442	\$17,338	\$6,039
New Jersey	\$1,749	\$2,345	\$14,893	\$16,456	\$6,091
New Mexico	\$1,907	\$2,176	\$11,701	\$14,180	\$3,818
New York	\$1,885	\$3,418	\$21,903	\$24,888	\$7,583
North Carolina	\$1,540	\$2,884	\$9,478	\$11,558	\$4,463
North Dakota	\$1,537	\$1,879	\$16,966	\$17,195	\$5,702
Ohio	\$1,357	\$2,364	\$19,843	\$14,873	\$5,265
Oklahoma	\$1,319	\$1,608	\$8,847	\$9,808	\$3,171
Oregon	\$1,598	\$1,823	\$9,689	\$10,196	\$3,345
Pennsylvania	\$1,780	\$2,491	\$14,452	\$9,756	\$5,268
Rhode Island	\$2,175	\$2,301	\$16,045	\$16,262	\$6,308
South Carolina	\$1,421	\$1,538	\$4,901	\$9,352	\$2,974
South Dakota	\$1,688	\$2,601	\$12,259	\$14,014	\$4,451
Tennessee	\$1,163	\$2,658	\$7,307	\$7,361	\$3,283
Texas	\$1,478	\$2,419	\$7,842	\$10,559	\$3,371
Utah	\$1,591	\$1,413	\$10,295	\$13,983	\$3,268
Vermont	\$2,095	\$1,713	\$7,849	\$12,970	\$3,977
Virginia	\$1,393	\$2,354	\$9,065	\$10,585	\$4,241
Washington	\$1,050	\$1,880	\$9,347	\$8,223	\$2,793
West Virginia	\$1,545	\$2,166	\$13,001	\$8,480	\$4,456
Wisconsin	\$1,076	\$2,012	\$9,272	\$12,922	\$4,317
Wyoming	\$1,517	\$2,476	\$13,118	\$16,377	\$4,220

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured

Alaska's average annual growth in expenditures (unadjusted for enrollment growth) also has consistently ranked above the national average, although the gap has recently been erased. Exhibit 3-5 below compares Alaska's average annual spending growth to the US as a whole over three time periods: 1991 – 2001, 2001 – 2004 and 2004 – 2005.²³ Exhibit 3-6 on the following page presents the same information for each of the 50 states and the District of Columbia.

See full list of states on next page – Exhibit 3-6

Exhibit 3-5 – Average Annual Medicaid Expenditure Growth - Alaska versus US



Although Alaska's upward spiral in costs eased somewhat in 2005 (and was projected to further ease in 2006, based on Management Plan estimates), the report issued earlier this year by The Lewin Group and ECONorthwest warns that this downward trend will be short lived. Lewin and ECONorthwest forecast that total spending between 2005 and 2010 will increase by 48 percent under current policies, or at an average annual rate of more than nine percent.²⁴ This would put the state nearly back to the double-digit increases experienced from 2000 – 2004.

²³ Data is for medical claims costs and disproportionate hospital expenditures and does not include administrative expenses.

²⁴ Source: Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005 – 2025, The Lewin Group, Inc. and ECONorthwest, Table 21 ("Forecast of Total Nominal [Actual] Spending on Alaska's Medicaid Program...Selected Calendar Years"), page 64

Exhibit 3-6 – Medicaid Expenditure Growth Rates by State

	Alaska & United States		
	FY1991 – 2001	FY2001 – 2004	FY2004 – 2005
United States	11%	9%	6%
Highest State	16%	23%	16%
Lowest State	7%	-1%	-16%
Alaska	13%	15%	6%
Alaska Rank	9th	3rd	26th

Individual State Avg Annual Growth in Medicaid Spending			
State	FY1991 – 2001	FY2001 – 2004	FY2004 – 2005
Alabama	12%	8%	5%
Alaska	13%	15%	6%
Arizona	15%	23%	16%
Arkansas	10%	10%	5%
California	11%	9%	9%
Colorado	13%	7%	6%
Connecticut	10%	6%	3%
Delaware	15%	10%	7%
District of Columbia	8%	4%	13%
Florida	12%	14%	3%
Georgia	11%	21%	-16%
Hawaii	11%	13%	14%
Idaho	15%	11%	6%
Illinois	11%	9%	6%
Indiana	10%	7%	7%
Iowa	9%	10%	6%
Kansas	12%	2%	10%
Kentucky	12%	8%	-1%
Louisiana	11%	6%	6%
Maine	11%	15%	10%
Maryland	10%	12%	12%
Massachusetts	7%	9%	8%
Michigan	10%	7%	-3%
Minnesota	9%	13%	-1%
Mississippi	13%	11%	-3%
Missouri	16%	9%	5%
Montana	9%	11%	3%
Nebraska	13%	6%	-4%
Nevada	15%	15%	14%
New Hampshire	13%	10%	8%
New Jersey	11%	4%	-5%
New Mexico	15%	15%	7%
New York	9%	9%	4%
North Carolina	14%	10%	11%
North Dakota	7%	6%	5%
Ohio	9%	11%	7%
Oklahoma	10%	7%	9%
Oregon	16%	-1%	8%
Pennsylvania	12%	9%	9%
Rhode Island	10%	12%	2%
South Carolina	12%	9%	5%
South Dakota	10%	6%	8%
Tennessee	13%	9%	8%
Texas	13%	12%	12%
Utah	11%	14%	8%
Vermont	13%	10%	8%
Virginia	10%	8%	13%
Washington	12%	7%	8%
West Virginia	13%	8%	14%
Wisconsin	8%	4%	8%
Wyoming	13%	15%	10%

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from the HCFA-64 report.

Part of the significant, and temporary, improvement in 2006 is due to the introduction of the Medicare Part D prescription drug benefit, which shifted responsibility for the drug costs of seniors with Medicaid coverage to the federal government. In its state fiscal year 2007 budget overview, DHSS estimated that the introduction of Part D would reduce Medicaid prescription drug expenditures by \$33 million in SFY 2007.²⁵ However, the Part D statute contains a “claw-back” provision under which the federal government will recoup from states an amount determined (through a formula) to be equal to what states would have spent absent Part D. DHSS in its budget projects that the formula will result in a recoupment of only \$21 million, leaving a net savings of \$12 million. However, in out years this gap is likely to close, as the formula is structured in a manner that most states believe will result in a ratcheting-up of the assessment.

Demographic trends are another contributor to program expenditure growth. The age 65 and older cohort in Alaska is growing rapidly and, within this segment, the 85 and older population is growing even faster. The elderly – particularly the 85 and older component – are an expensive population segment within Medicaid, even with Medicare serving as primary payer for acute care services, because of Medicaid’s dominant role on the long-term care side. Alaska’s policies with respect to service coverage and payment have further intensified the issue (See the Long-Term Care section for a more detailed discussion of this topic.)

Faced with these trends, Alaska – like every other state – has sought short-term relief in the form of cost containment initiatives, as discussed in the next section below.

Cost Containment

Although Alaska’s expenditure growth rate has exceeded the national average, every state has grappled in recent years with rising Medicaid costs. During the past two fiscal years – even as medical inflation has abated somewhat – nearly every state has launched one or more cost containment initiatives.

Exhibits 3-7 and 3-8 on the following pages summarize the level of cost containment activity across the 50 states and District of Columbia in 2005 and 2006. As they illustrate, most states have targeted provider payments in general and pharmacy expenditures, in particular.

²⁵ *DHSS SFY 2007 Budget Overview, Page 43*

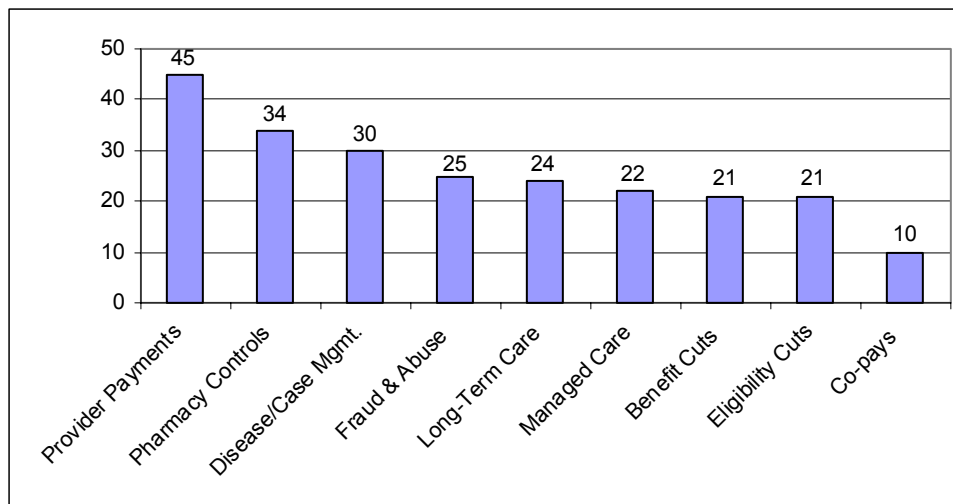
Over half the states also have invested in disease management programs, a concept gaining favor as the number of chronically ill and disabled persons enrolled in Medicaid continues to grow. (See Chapter 6 for a more detailed discussion of disease management initiatives.)

About one-half of the states have undertaken new initiatives to curb fraud and abuse and to rein in spending on long-term care. Smaller numbers of states – usually those in the greatest fiscal distress – have pursued eligibility and/or benefit cuts.

Only ten states have sought to raise co-payments on beneficiaries, partly because prior to passage of the Deficit Reduction Act last year, states were constrained by federal law from imposing more than nominal cost sharing on categorically-needy beneficiaries. The number of states electing to raise cost sharing requirements will likely grow in coming years.

Exhibit 3-7 – Cost Containment Initiatives Nationally (2005 & 2006)

See full list of
states on next
page – Exhibit 3-8



Source: StateHealthFacts.org

Exhibit 3-8 – Cost Containment Activities by State (2005 & 2006)

United States									
	Provider Payments	Pharmacy Controls	Benefit Reduction	Eligibility Cuts	Co-Pays	Managed Care Initiatives	Disease/ Case Mgmt	Fraud & Abuse	Long-Term Care (LTC)
United States	45 Yes + DC	34 Yes +DC	21 Yes	21 Yes	10 Yes	22 Yes + DC	30 Yes +DC	25 Yes	23 Yes

Individual State Medicaid Cost Containment Actions									
State	Provider Payments	Pharmacy Controls	Benefit Reduction	Eligibility Cuts	Co-Pays	Managed Care Initiatives	Disease/ Case Mgmt	Fraud & Abuse	Long-Term Care (LTC)
Alabama	Yes	Yes	No	No	No	No	Yes	Yes	Yes
Alaska	Yes	Yes	No	No	No	No	No	Yes	Yes
Arizona	Yes	No	No	No	No	No	No	No	No
Arkansas	Yes	Yes	No	No	No	No	Yes	Yes	No
California	Yes	No	Yes	No	No	Yes	Yes	Yes	No
Colorado	Yes	No	No	Yes	No	Yes	Yes	No	No
Connecticut	Yes	No	No	Yes	No	No	No	No	No
Delaware	Yes	Yes	No	No	No	No	Yes	No	No
District of Columbia	Yes	Yes	No	No	No	Yes	Yes	No	No
Florida	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes
Georgia	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes
Hawaii	Yes	No	No	No	No	No	No	No	No
Idaho	Yes	Yes	Yes	Yes	No	No	Yes	No	No
Illinois	Yes	No	Yes	No	No	Yes	Yes	Yes	No
Indiana	Yes	Yes	No	No	No	No	No	No	Yes
Iowa	No	Yes	No	No	No	Yes	Yes	Yes	Yes
Kansas	No	Yes	No	No	No	Yes	Yes	No	Yes
Kentucky	Yes	Yes	Yes	No	Yes	No	Yes	No	No
Louisiana	Yes	No	No	No	No	No	No	Yes	Yes
Maine	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes
Maryland	Yes	Yes	Yes	No	Yes	No	No	Yes	Yes
Massachusetts	No	Yes	No	No	No	Yes	No	Yes	No
Michigan	Yes	Yes	No	Yes	Yes	No	Yes	No	No
Minnesota	Yes	Yes	Yes	Yes	No	Yes	No	No	Yes
Mississippi	Yes	Yes	Yes	Yes	No	No	No	No	No
Missouri	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes
Montana	Yes	Yes	No	Yes	No	No	No	No	No
Nebraska	Yes	Yes	No	No	No	Yes	No	Yes	No
Nevada	Yes	No	No	No	No	No	Yes	No	Yes
New Hampshire	Yes	No	No	No	No	No	Yes	Yes	No
New Jersey	Yes	No	No	No	No	No	Yes	Yes	No
New Mexico	Yes	Yes	No	Yes	No	No	No	No	No
New York	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
North Carolina	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
North Dakota	No	Yes	No	No	No	No	Yes	No	No
Ohio	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Oklahoma	Yes	Yes	No	No	No	No	Yes	Yes	No
Oregon	Yes	No	Yes	Yes	No	No	Yes	No	No
Pennsylvania	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No
Rhode Island	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes
South Carolina	Yes	No	Yes	Yes	No	Yes	No	Yes	Yes
South Dakota	No	Yes	No	No	No	No	No	No	Yes
Tennessee	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes
Texas	Yes	No	Yes	No	No	Yes	No	No	Yes
Utah	Yes	Yes	Yes	No	No	No	Yes	Yes	No
Vermont	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes
Virginia	Yes	No	No	No	No	Yes	Yes	Yes	Yes
Washington	Yes	No	No	No	No	No	Yes	Yes	Yes
West Virginia	Yes	Yes	Yes	Yes	No	Yes	Yes	No	No
Wisconsin	Yes	Yes	No	No	No	Yes	No	Yes	No
Wyoming	Yes	Yes	No	No	No	No	No	No	No

Source: US Census Bureau Current Population Survey (2005)

Alaska's recent cost containment initiatives have encompassed four of the five most common areas, with disease/case management being the sole exception. DHSS's actions are described in greater detail later in this chapter and the next, but have included:

- *Provider Payments* – DHSS froze rates to Pioneer Homes in FY 2006 and did not request funding for a rate increase for FY 2007
- *Pharmacy Controls* – DHSS has instituted a preferred drug list and is gradually moving from a voluntary system of compliance to a mandatory one
- *Fraud & Abuse* – The Department has established a Program Integrity unit, with centralized responsibility for investigating and acting on suspected cases of fraudulent billing by providers
- *Long-Term Care* – The Department has taken initial steps to curb the fast-growing Personal Care Attendant program, while considering broader reforms aimed at long-term care eligibility determination and rate setting

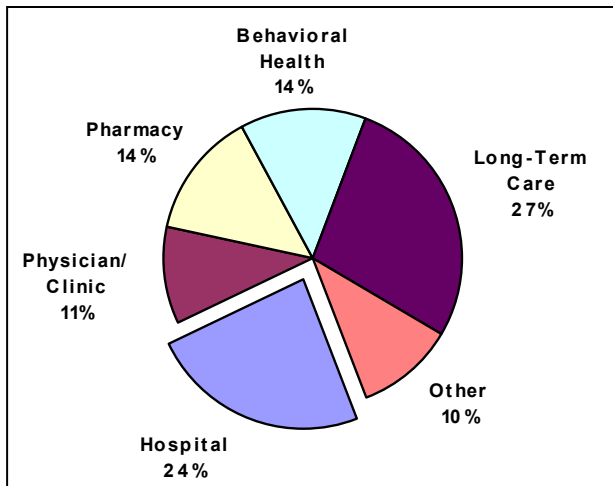
Though essential, cost containment efforts must be balanced against the need to preserve access to services through adequate payment rates to providers. Portions of the provider system serving Alaska Medicaid beneficiaries – such as behavioral health – are relatively fragile. Cost containment efforts should be pursued thoughtfully, so as not to produce the unintended result of reducing access to lower-cost providers through untargeted cuts to the system. For example (and as discussed in more detail later in the chapter), the state is part way through strengthening its historically fragile behavioral health treatment system for adolescents. If the system's capacity is inadvertently reduced, the result would be more placements at costlier out-of-state facilities.

The next several sections of the chapter address the major Medicaid service categories, beginning with hospital services and proceeding onto physicians/clinics, pharmacy, long-term care and behavioral health.

Hospital Services

Inpatient and outpatient hospital services (non-psychiatric) accounted for about one-quarter of Alaska Medicaid provider payments in state fiscal year 2005, with the spending split roughly two-thirds for inpatient and one-third for outpatient services.²⁶

Exhibit 3-9 – Hospital Services as Portion of Expenditures (2005)



Source: DHSS FY 2007 Budget Overview

Inpatient Hospital

DHSS reimburses hospitals for inpatient services using a prospective, cost-based per diem payment methodology. Payment rates are calculated on a hospital-specific basis using data submitted on prior year cost reports and, by regulation, must be updated at least biennially.

Alaska was one of 18 states in 2004 to use a per diem payment system, as compared to 28 which paid by diagnosis-related group (DRG).²⁷ While per diems were the most common payment system in the 1980s and into the 1990s, many states in the past decade have followed Medicare's lead and shifted to DRGs. Under a DRG system, each patient is "mapped" to a diagnosis-related group and payment is made in lump sum to the hospital based on the average length of stay for patients within the DRG.

²⁶ "Long-Term Forecast of Medicaid Spending in Alaska: 2005 – 2025", The Lewin Group and ECONorthwest, page 63.

²⁷ Source: Kaiser Commission on Medicaid and the Uninsured. The remaining handful of states used a variety of methods, including directly negotiated rates and all-inclusive case rates covering both professional and institutional costs.

The advantage of DRGs over a per diem system to Medicaid, as the payer, is that financial risk for longer than average hospital stays is shifted to the hospital. However, most states have felt obliged to create DRG systems specific to their own experience, when adopting this type of system. Because there are hundreds of individual diagnosis-related groups for which payment rates must be established, states with relatively fewer hospitals and patient days can have difficulty establishing appropriate rates.

There are tools available to states with per diem systems to provide incentives to hospitals to discharge patients as soon as it is medically appropriate to do so. Some states, including Arizona, Delaware and Louisiana, use tiered per diem rates, such that the daily payments fall as patients move from critical to stable condition.

States with per diems also typically define a limit, in terms of number of days, beyond which hospitals must seek prior authorization for extending the patient's stay. DHSS requires prior approval for non-emergency admissions and for lengths of stay exceeding two, three or four days (depending on the basis of admission).

Finally, states can impose higher co-payments for hospital services than many other Medicaid service types, though this typically has the effect of shifting part of the cost to the hospital in the form of uncompensated care (assuming the patient is unable to pay), rather than discourage utilization. Alaska's co-payment of \$50 per day, up to the lesser of \$200 or one-half of the first day's payment is the highest in the nation for individuals hospitalized for more than two days.²⁸

In federal fiscal year 2003, the most recent year for which national data is available, Alaska spent just under \$1,200 per Medicaid enrollee for inpatient services, fourth highest in the country, after the District of Columbia, Illinois and New York (see Exhibit 3-10 on the next page). Alaska's average cost was slightly more than double the national average.²⁹ (In state fiscal year 2005, the amount spent per enrollee was up to \$1,462.)

These higher than average costs occurred in spite of lower than average utilization. In 2004, Alaska had the lowest admission rate and hospital days rate per 1,000 in the nation across all payer groups (see Exhibit 3-11 on the next page for hospital utilization statistics).

²⁸ Several states, including Montana, Tennessee and Virginia impose a flat \$100 co-payment at admission.

²⁹ Source: Centers for Medicare and Medicaid Services, National MSIS Data. CMS groups capitated managed care payments in a single category, thereby artificially reducing the costs per enrollee in other categories within states with large managed care programs. However, Alaska also exceeds states with little or no managed care, such as North Dakota, South Dakota, Vermont and Wyoming.

Exhibit 3-10 – Average Hospital Expenditures per Beneficiary by State (2003)

	Alaska & United States	
	Inpatient	Outpatient
United States	\$573	\$168
Highest State	\$1,475	\$591
Lowest State	\$112	\$27
Alaska	\$1,194	\$447
Alaska Rank	4th	2nd

Individual State Expenditures per Beneficiary – 2003		
State	Inpatient	Outpatient
Alabama	\$226	\$59
Alaska	\$1,194	\$447
Arizona	\$112	\$183
Arkansas	\$369	\$108
California	\$346	\$47
Colorado	\$520	\$162
Connecticut	\$324	\$140
Delaware	\$223	\$47
District of Columbia	\$1,475	\$104
Florida	\$767	\$141
Georgia	\$684	\$370
Hawaii	\$229	\$55
Idaho	\$629	\$187
Illinois	\$1,447	\$266
Indiana	\$434	\$158
Iowa	\$483	\$245
Kansas	\$554	\$74
Kentucky	\$414	\$338
Louisiana	\$647	\$238
Maine	\$884	\$591
Maryland	\$622	\$142
Massachusetts	\$357	\$228
Michigan	\$502	\$102
Minnesota	\$402	\$97
Mississippi	\$609	\$282
Missouri	\$408	\$208
Montana	\$584	\$260
Nebraska	\$506	\$229
Nevada	\$721	\$131
New Hampshire	\$304	\$370
New Jersey	\$458	\$356
New Mexico	\$400	\$132
New York	\$1,205	\$285
North Carolina	\$617	\$375
North Dakota	\$469	\$343
Ohio	\$646	\$192
Oklahoma	\$312	\$69
Oregon	\$179	\$109
Pennsylvania	\$236	\$27
Rhode Island	\$510	\$144
South Carolina	\$915	\$152
South Dakota	\$679	\$268
Tennessee	\$265	\$224
Texas	\$634	\$80
Utah	\$649	\$177
Vermont	\$270	\$271
Virginia	\$367	\$140
Washington	\$418	\$158
West Virginia	\$746	\$271
Wisconsin	\$337	\$123
Wyoming	\$577	\$186

Source: StateHealthFacts.org

Exhibit 3-11 – Hospital Capacity & Utilization Data by State (2004)

	Alaska & United States				
	Hospital Beds (per 1,000 population)	Hospital Admissions (per 1,000 population)	Hospital Inpatient Days (per 1,000 population)	Hospital Outpatient Visits (per 1,000 population)	Hospital Emergency Room Visits (per 1,000 population)
United States	2.8 ¹	119 ¹	673 ¹	1,946 ¹	383 ¹
Highest State	6.2	254	1,771	3,661	675
Lowest State	1.8	69	394	942	258
Alaska	2.2	69	435	2,023	385
Alaska Rank	39 th	51 st	47 th	27 th	31 st

State	Hospital Beds (per 1,000 population)	Hospital Admissions (per 1,000 population)	Hospital Inpatient Days (per 1,000 population)	Hospital Outpatient Visits (per 1,000 population)	Hospital Emergency Room Visits (per 1,000 population)
Alabama	3.4	158	810	1,826	448
Alaska	2.2	69	435	2,023	385
Arizona	1.9	109	485	942	304
Arkansas	3.5	139	746	1,761	444
California	2.0	97	512	1,324	280
Colorado	2.0	95	467	1,511	292
Connecticut	2.2	111	643	2,002	406
Delaware	2.4	124	774	2,248	392
District of Columbia	6.2	254	1,771	2,933	675
Florida	2.9	134	696	1,287	390
Georgia	2.8	106	683	1,502	392
Hawaii	2.5	91	694	1,471	258
Idaho	2.5	91	479	1,742	344
Illinois	2.7	125	661	2,229	389
Indiana	3.0	117	652	2,491	422
Iowa	3.7	122	799	3,280	361
Kansas	3.8	121	774	2,144	342
Kentucky	3.7	146	817	2,144	545
Louisiana	3.8	154	856	2,303	548
Maine	2.7	115	624	3,131	541
Maryland	2.1	119	573	1,246	389
Massachusetts	2.5	125	691	2,971	449
Michigan	2.6	118	622	2,745	411
Minnesota	3.2	123	786	1,870	306
Mississippi	4.5	147	955	1,453	552

Exhibit 3-11 – Hospital Capacity & Utilization Data by State (2004) – cont'd

State	Hospital Beds (per 1,000 population)	Hospital Admissions (per 1,000 population)	Hospital Inpatient Days (per 1,000 population)	Hospital Outpatient Visits (per 1,000 population)	Hospital Emergency Room Visits (per 1,000 population)
Missouri	3.3	144	765	2,810	445
Montana	4.7	115	1,125	3,124	318
Nebraska	4.2	121	923	2,260	316
Nevada	2.0	100	534	1,048	260
New Hampshire	2.2	90	499	2,284	434
New Jersey	2.5	127	681	2,041	349
New Mexico	1.9	86	410	2,649	381
New York	3.3	131	959	2,579	395
North Carolina	2.8	118	716	1,793	408
North Dakota	5.6	138	1,210	2,906	400
Ohio	2.9	129	674	2,668	472
Oklahoma	3.1	129	673	1,513	385
Oregon	1.8	95	407	2,188	319
Pennsylvania	3.2	149	828	2,696	426
Rhode Island	2.2	116	615	1,985	400
South Carolina	2.7	122	696	1,678	404
South Dakota	6.0	134	1,350	2,039	279
Tennessee	3.5	140	793	1,741	502
Texas	2.6	112	587	1,444	354
Utah	1.9	90	394	1,949	342
Vermont	2.4	85	559	3,661	421
Virginia	2.3	103	597	1,597	390
Washington	1.8	85	397	1,626	334
West Virginia	4.1	164	942	3,335	624
Wisconsin	2.6	109	606	2,148	338
Wyoming	4.0	100	780	1,819	426

Sources: - 2004 AHA Annual Survey Copyright 2005 by Health Forum LLC, an affiliate of the American Hospital Association, special data request, February 2006
- 2004 population data from Annual Population Estimates by State, 01Jul04 Population, US Census Bureau

Notes: Data are for community hospitals, which represent 85% of all hospitals. Federal hospitals, long-term care hospitals, psychiatric hospitals, institutions for the mentally retarded, and alcoholism and other chemical dependency hospitals are not included.

¹ US total excludes the territories (87 hospital admissions per 1,000 population in Puerto Rico)

Outpatient Hospital

Alaska reimburses hospitals for outpatient services through a facility-specific, percentage of charges methodology. Ambulatory Surgery Center procedures are reimbursed using a grouper methodology – similar to DRGs – favored by most states.

In federal fiscal year 2003, Alaska spent about \$450 per Medicaid enrollee for outpatient hospital services, second in the nation to Maine. The national average was \$168 per eligible (see Exhibit 3-10 on the second previous page.) This occurred despite the average level of utilization among the state's residents.

Alaska's higher costs are likely due in part to the payment methodology, which imposes no penalty on higher-cost/higher-charge facilities. However, the state also is reliant on hospitals in very rural areas to provide a portion of the routine care that in more urban states is available from physicians or free standing clinics.

Some state Medicaid programs have implemented prospective payment systems for certain outpatient services, particularly surgical procedures. States implemented prospective systems in response to double-digit growth in expenditures for outpatient hospital systems and few incentives for hospitals to contain costs and utilization under charge-based reimbursement methodologies.

State approaches frequently build on the prospective payment approach for Medicare reimbursement, based on ambulatory patient classifications (APCs).³⁰ Under these approaches, outpatient hospital claims are grouped into one of 459 APCs. Each APC is intended to group encounters that are clinically comparable and require a similar amount of resources. Based on the assigned APC, the program makes a fixed, all-inclusive payment for most services provided during a visit.

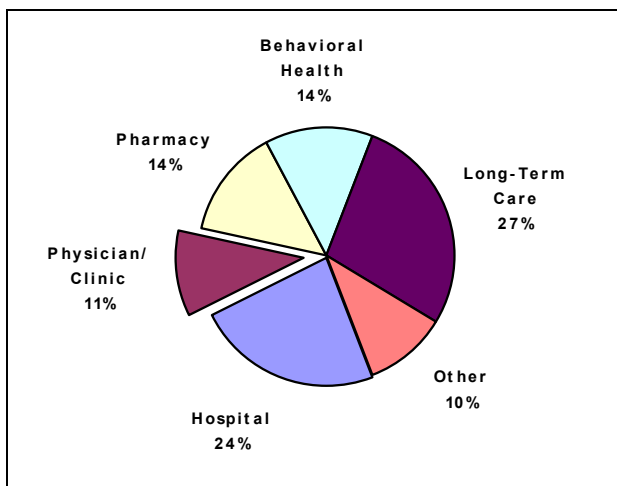
Implementation of a prospective payment system is relatively complex, frequently requiring a great deal of staff resources and complex changes to the Medicaid Management Information System (MMIS). In spite of these challenges, small rural states, including Iowa and Montana, have adopted prospective outpatient reimbursement systems.

³⁰ Indian Health Service hospitals are exempt from the Medicare Outpatient Prospective Payment System

Physician/Clinic Services

Physician and clinic services accounted for about one-tenth of Alaska’s Medicaid expenditures in state fiscal year 2005. Alaska has historically ranked first in terms of payment rates to physicians, regardless of specialty, as reflected in the 2005 national data presented in Exhibit 3-13 on the next page. And, as would be expected, Alaska in federal fiscal year 2003 spent more per enrollee on this service than any other state.

Exhibit 3-12 – Physician/Clinic Services as Portion of Expenditures (2005)



Source: DHSS FY 2007 Budget Overview

One of the drivers behind Alaska’s higher expenditures – in addition to the higher physician payment rates – is the state’s ability to pay tribal health clinics the federally-established rate for Indian Health Service/Tribal Health providers. This rate – which currently stands at \$406 per encounter – is reimbursed at a 100 percent match rate by the federal government for Native Alaskan beneficiaries seen at these clinics. Because this rate serves as a subsidy for uncompensated care at clinics, it supports Alaska’s health care infrastructure at no cost to the state.

Similarly, the state has seen an increase in the number of “330 look-alike” clinics, which receive reasonable cost reimbursement in return for meeting most of the qualification standards of FQHCs.

Exhibit 3-13 – Comparison of Physician Fee Schedules by State (2003)

	Alaska & United States			
	All Services	Primary Care	Obstetrics	Other Services
United States	1.00	1.00	1.00	1.00
Highest State	2.28	2.50	1.90	2.19
Lowest State	0.56	0.58	0.41	0.46
Alaska	2.28	2.50	1.90	2.19
Alaska Rank	1 st	1 st	1 st	1 st

Individual State Medicaid Physician Fee Index – 2003				
State	All Services	Primary Care	Obstetrics	Other Services
Alabama	1.21	1.23	1.35	0.97
Alaska	2.28	2.50	1.90	2.19
Arizona	1.55	1.63	1.44	1.49
Arkansas	1.24	1.37	0.83	1.39
California	0.91	0.87	0.83	1.09
Colorado	1.06	1.08	1.03	1.04
Connecticut	1.30	1.33	1.53	0.96
Delaware	1.49	1.64	1.09	1.41
District of Columbia	0.78	0.62	1.24	0.63
Florida	0.95	0.96	1.04	0.83
Georgia	1.13	1.05	1.18	1.24
Hawaii	1.14	1.21	0.99	1.13
Idaho	1.22	1.31	1.08	1.18
Illinois	0.92	0.89	1.03	0.93
Indiana	0.92	0.91	0.84	1.02
Iowa	1.30	1.39	1.12	1.28
Kansas	1.00	0.93	1.05	1.10
Kentucky	1.01	0.94	1.20	1.07
Louisiana	1.04	1.05	1.05	0.97
Maine	0.89	0.84	0.96	0.93
Maryland	1.21	1.28	1.20	1.05
Massachusetts	1.25	1.28	1.28	1.16
Michigan	0.96	1.06	0.82	0.89
Minnesota	1.09	1.00	0.94	1.47
Mississippi	1.19	1.32	0.75	1.23
Missouri	0.76	0.75	0.83	0.71
Montana	1.13	1.11	1.08	1.26
Nebraska	1.22	1.13	1.01	1.70
Nevada	1.43	1.17	1.67	1.79
New Hampshire	1.03	1.09	1.15	0.77
New Jersey	0.56	0.61	0.41	0.65
New Mexico	1.31	1.41	1.11	1.31
New York	0.70	0.71	0.88	0.46
North Carolina	1.34	1.47	1.15	1.28
North Dakota	1.23	1.33	0.97	1.16
Ohio	0.97	1.03	0.89	0.87
Oklahoma	0.95	1.00	0.88	0.93
Oregon	1.18	1.17	1.33	1.03
Pennsylvania	0.74	0.67	1.04	0.80
Rhode Island	0.62	0.58	0.63	0.72
South Carolina	1.17	1.12	1.62	0.97
South Dakota	1.05	0.98	0.94	1.35
Tennessee	N/A ¹	N/A ¹	N/A ¹	N/A ¹
Texas	0.99	0.96	0.93	1.09
Utah	1.01	1.02	0.98	1.00
Vermont	1.12	1.00	1.30	1.22
Virginia	1.08	1.15	0.97	1.05
Washington	1.24	1.27	1.46	0.90
West Virginia	1.21	1.22	1.35	1.09
Wisconsin	1.19	1.13	1.20	1.35
Wyoming	1.40	1.47	1.25	1.41

Source: StateHealthFacts.org

¹ Tennessee's Medicaid program did not have a fee-for-service component in 2003

Overall, Medicaid's payment rates to physicians and clinic providers is perceived by physicians in the state – as represented by the Alaska Medical Association – to be a life support for their practices. While in most states Medicaid is the poorest payer – after commercial insurance and Medicare – in Alaska the rate has been pegged to the state's uniquely high Medicare fee schedule, established to recognize the state's higher salary and other living costs. At the same time, there has not been an adjustment to the Medicaid fee schedule since 1998 and Alaska's favorable Medicare payment rates will fall by more than 30 percent when an existing geographic adjustment of 1.67 expires on January 1, 2007 in accordance with Medicare Modernization Act provisions.

Any reduction in physician payment rates outside of Medicaid will put further pressure on the program to maintain the fee schedule at a level that supports physician practices. Currently, Alaska has about 14 percent fewer physicians than the national average and the state ranks 42nd, in terms of physicians per 100,000 residents (see Exhibit 3-14 on the next page). This shortfall is projected to continue over the next decade, even assuming no change in current payment policy.³¹ Medicaid's rates, high as they are, serve a broader policy purpose for the state in terms of bolstering the supply of physicians.

One promising way to stretch the physician supply is telemedicine. Alaska implemented regulations for Medicaid telehealth reimbursement in 2002, placing Alaska at the forefront of this emerging trend in medicine. While the deployment of the physical infrastructure is progressing rapidly, Medicaid claims data reveals that overall utilization is relatively low. Among providers that currently offer telemedicine options, billing for the services remains dysfunctional.

State Medicaid reports reveal little utilization of the services.³² Given the number of Medicaid beneficiaries that live in remote areas, and that lack access to specialized medical care, telehealth is a cost-effective way of gaining access to specialty physicians. The state continues to work with Medicaid providers to establish the framework for billing and the technical support necessary to ensure that Medicaid beneficiaries can access the benefits of these services.

³¹ Source: *Alaska Physician Supply Task Force Report (July, 2006)*

³² Alaska Telehealth Advisory Council 2004 Final Report

Exhibit 3-14 – Physicians per 100,000 Population by State

	Alaska & United States
	Non-Federal Physicians (per 1,000 population)
United States	281 ¹
Highest State	752
Lowest State	175
Alaska	217
Alaska Rank	42nd

State	Non-Federal Physicians (per 1,000 population)
Alabama	216
Alaska	217
Arizona	225
Arkansas	205
California	261
Colorado	268
Connecticut	369
Delaware	272
District of Columbia	752
Florida	258
Georgia	219
Hawaii	302
Idaho	175
Illinois	284
Indiana	222
Iowa	218
Kansas	235
Kentucky	233
Louisiana	262
Maine	302
Maryland	389
Massachusetts	451
Michigan	289
Minnesota	283
Mississippi	182
Missouri	267
Montana	224
Nebraska	243
Nevada	196
New Hampshire	267
New Jersey	333
New Mexico	238
New York	401
North Carolina	252
North Dakota	244
Ohio	289
Oklahoma	205
Oregon	269
Pennsylvania	332
Rhode Island	361
South Carolina	231
South Dakota	217
Tennessee	262
Texas	219
Utah	215
Vermont	363
Virginia	264
Washington	266
West Virginia	254
Wisconsin	262
Wyoming	191

Sources: 2004 AHA Annual Survey; US Census Bureau CPS

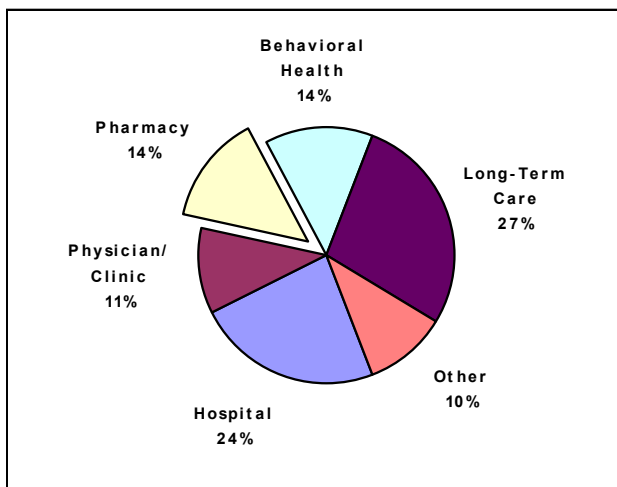
Pharmacy

Prescription drug (pharmacy) payments accounted for about 14 percent of Alaska Medicaid expenditures in state fiscal year 2005. Total expenditures, before pharmacy rebates stood at \$133 million; expenditures net of rebates were \$95 million.³³ (The chart below is before rebates.)

In fiscal year 2003, the most recent year for which national data is available, Alaska's prescription drug expenditures per beneficiary (before rebates and prior to introduction of Medicare Part D) were \$788, above the national average of \$611 and thirteenth highest in the country. (In state fiscal year 2005, the amount per enrollee was \$1,018 before rebates and \$730 after rebates.³⁴)

Alaska's ranking likely would have been higher still if not for its greater than average enrollment of children, and smaller than average enrollment of elderly persons.

Exhibit 3-15 – Pharmacy as Portion of Expenditures (2005)



Source: DHSS FY 2007 Budget Overview

³³ Source: DHSS FY 2007 Budget Overview. Under federal law, drug manufacturers are required to rebate a portion Medicaid program prescription drug costs, to comply with best price requirements. Alaska receives about 27 percent of its gross pharmacy expenditures back in the form of a rebate.

³⁴ Before rebate figure calculated from The Lewin Group and ECONorthwest report; after rebate figure calculated from FY 2007 Budget Overview data.

Prescription drugs have been the fastest growing component of health care costs nationally – across all payers – for over a decade. The introduction of Medicare Part D will provide some relief to states in terms of the drug costs, but, as discussed earlier, the improvement will likely be temporary.

State Medicaid programs have employed a variety of tools in recent years to try to reduce the rate of growth within their prescription drug programs (see exhibit 3-15 for information on pharmacy programs in the 50 states), including:

- Purchasing Pools
- Preferred Drug Lists/Prior Authorization
- Pricing Strategies
- Generic Substitution Requirements/Coverage Limits
- Beneficiary Cost Sharing
- Increased Patient Management

Purchasing Pools

Alaska is already part of a multi-state pool that contracts with the First Health Services Corporation to serve as a purchaser on behalf of its member states.³⁵ The expectation of these pools, which have become fairly commonplace in recent years, is that combining lives from several programs will enable the purchaser to secure favorable prices. Medicaid pays First Health a flat administrative fee, plus a per-claim fee for every prescription purchased. First Health also is Alaska's Medicaid Management Information System contractor, though it is in the process of being replaced (see Chapter 4). First Health's loss of the MMIS contract will not affect its role on the pharmacy side.

Preferred Drug Lists/Prior Authorization

Preferred drug lists (PDLs) are essentially formularies created to encourage physicians to prescribe generic equivalents to brand drugs, when available, and products for which drug manufacturers have agreed to offer additional, supplemental rebates. To increase their effectiveness, PDLs often are accompanied by prior authorization requirements for drugs not on the list.

³⁵ The other members of the pool are Hawaii, Minnesota, Montana, Nevada, New Hampshire and Vermont.

Alaska Medicaid has a PDL in place, but until this fall made compliance with list voluntary. While provider compliance under the voluntary rules has been a relatively strong 86 percent, DHSS is now gradually introducing prior authorization requirements for non-PDL drugs, starting with psychotropic medications. Psychotropics are among the costliest of medications, making this an appropriate drug class to address first. However, most state Medicaid programs have prior authorization programs in place and many impose prior authorization requirements across all drug classes.

As a next step, Medicaid should extend prior authorization requirements to those drug categories that have adequate coverage on the PDL, from a clinical and safety standpoint. Other prior authorization programs also should be established for drugs with high inappropriate prescribing potential.

Pricing Strategies

Alaska Medicaid uses a common method to reimburse pharmacies for medication dispensed to their members. The pharmacies are reimbursed for ingredient cost at a rate of average wholesale price (AWP) minus five percent. AWP represents the manufacturers' and distributors' reported wholesale price, but does not reflect any discounts or rebates. The rate at which Alaska Medicaid is reimbursing pharmacies for ingredient cost is higher than any other state using the AWP reimbursement method.

And starting in January 2007, the Centers for Medicare and Medicaid Services (CMS) will change the federal government's calculation for state drug funding to one based on average manufacturer's price (AMP). The AMP is considered to more accurately reflect the true baseline price of a drug, thereby allowing for better control over reimbursement to pharmacies. CMS is following the lead of a number of states that have made the same conversion in recent years.

The second component of pricing is the pharmacy dispensing fee, which is paid on every prescription filled. Currently, Alaska Medicaid dispensing fees range from \$3.45 to \$11.46 per prescription, depending on the circumstance. The higher end of the range is greater than most Medicaid programs allow for dispensing fees.

Alaska's higher-than-average dispensing fees serve a useful purpose in rural areas where there may only be one pharmacy serving a community or group of communities. These

pharmacies depend on Medicaid revenues to remain in operation. However, there is no apparent shortage of participating pharmacies in Anchorage. Medicaid could consider introducing a tiered payment schedule that locks in higher rates for “critical-access” sole providers in rural areas, while implementing lower rates in urban centers. The state could further establish “peer groups” within urban areas and target the discounted price to large, chain-based pharmacies, while continuing to pay a higher rate to smaller, independent pharmacies.

Generic Substitution/Coverage Limits

Every state encourages the use of generic substitutions for brand name drugs, when generics are available. Alaska’s generic substitution rate stands in line with the national average at 52 percent. A growing number of states have sought to more aggressively encourage generic substitution both through the prior authorization process and/or by limiting coverage of brand drugs (for adults) to a maximum number of prescriptions per month. For example, Oklahoma currently has a limit of six prescriptions per month for non-long-term care enrollees, of which only three can be brand name.

Coverage limits can have unintended consequences, if lack of access to needed drugs results in a costly trip to the emergency room or a hospital stay. However, limits targeted to brand name drugs, if accompanied by the ability to override the limit on a case-by-case basis through prior authorization can encourage higher generic utilization. Because generic equivalent drugs typically cost 30 – 75 percent less than the brand name version, even a modest shift toward generic utilization can measurably affect a program’s overall drug costs.

Beneficiary Cost Sharing

Medicaid programs have historically been able only to charge nominal co-payments for most covered services, including prescription drugs, as reflected on the 2003 data in Exhibit 3-16 on the next page. However, Deficit Reduction Act provisions that took effect earlier this year permit states to charge co-insurance of up to ten percent of the cost of a service for persons with family incomes between 100 and 150 percent of the FPL, and up to 20 percent of the cost of a service for persons with family incomes above 150 percent of the FPL. The coinsurance requirement can also be made enforceable; that is, persons unable or unwilling to pay can be denied the service.

Exhibit 3-16 – Pharmacy Program Characteristics by State

State	Expenditure per Beneficiary (net of rebates)	Co-Payment	Coverage Limitations	Reimbursement	Dispensing Fee	Generic Utilization Rate (%)
Alabama	\$601	\$0.50 – \$3/Rx depending on drug cost	4 brand Rx/month except brand anti-psychotics and anti-retrovirals up to 10 Rx/month	AWP – 10% or WAC + 9.2%	\$5.40	
Alaska	\$788	\$2/Rx		AWP – 5%	\$3.45 - \$11.46	52
Arizona	N/A			Varies		71
Arkansas	\$482	\$0.50 – \$3/Rx depending on drug cost	6 Rx/month except for persons in nursing facilities; Rx must be generic unless DAW	AWP – 14% brand; AWP – 20% generic	\$5.51	47
California	\$400	\$1/Rx	Most drugs limited to 100-day supply	AWP – 17%	\$7.25	52
Colorado	\$530	\$1/generic or multi-source Rx; \$3/brand or single source Rx	8 Rx/month	Lesser of AWP – 13.5% or WAC + 18%	\$4.00	54
Connecticut	\$801		30-day supply for acute conditions; 30-day supply or 240 dosage units for chronic conditions	AWP – 12%; -40% for MAC drugs	\$3.15	42
Delaware	\$708		Rx must be generic unless DAW	AWP – 14%	\$3.65	
District of Columbia	\$527	\$1/Rx		AWP – 10%	\$4.50	46
Florida	\$726		4 brand Rx/month	AWP – 15.4%	\$4.23	46
Georgia	\$612	\$0.50/preferred drug or generic Rx; \$0.50–\$3/ non-preferred or brand Rx depending on drug cost	5 Rx or refills/month	AWP – 11%	\$4.33 – \$4.63 + \$0.50 generics	
Hawaii	\$446			AWP – 10.5%	\$4.67	
Idaho	\$658			AWP – 12%	\$5.00	54
Illinois	\$578	\$3/brand Rx		AWP – 12% brand; AWP – 25% generic	\$3.40 brand; \$4.60 generic	61
Indiana	\$694	\$3/Rx		AWP – 12%; WAC – 20% generic	\$4.90	53
Iowa	\$859	\$1/generic Rx; \$0.50–\$3/brand Rx depending on payment		AWP – 12%	\$4.26	51
Kansas	\$723	\$3/Rx	Adult vitamins limited to pregnancy supplements	AWP – 13% single source; AWP – 27% multi-source	\$3.40	60
Kentucky	\$857	\$1/Rx		AWP – 12%	\$4.51	
Louisiana	\$743	\$0.50–\$3/Rx depending on drug cost	30-day supply or 100 dosage units; 8 Rx/month	AWP – 13% independents; AWP – 15% chains	\$0.00 – \$5.77	57

Exhibit 3-16 – Pharmacy Program Characteristics by State – cont'd

State	Expenditure per Beneficiary (net of rebates)	Co-Payment	Coverage Limitations	Reimbursement	Dispensing Fee	Generic Utilization Rate (%)
Maine	\$737	\$2.50/Rx up to \$25/month; no co-payment required for mail order Rx	5 brand Rx/month for residents in supervised settings	AWP – 15%	\$3.35 – \$12.50	
Maryland	\$460	\$1/Rx for generic or preferred brand; \$2/Rx for non-preferred brand	Specified quantity limits for selected drugs	AWP – 12%; WAC + 8%	\$3.69 PDL; \$2.69 non-PDL	50
Massachusetts	\$786	\$1/generic Rx or OTC product; \$3/brand Rx		WAC + 5%	\$3.00 + \$2.00 for compounds	57
Michigan	\$479	\$1/Rx		AWP – 13.5% independents; AWP – 15% chains	\$2.50	56
Minnesota	\$461	A – \$1/generic Rx; \$3/brand Rx up to \$20/month B – \$3/Rx; anti-psychotic Rx not subject to co-payments; See state-specific FN		AWP – 11.5% or MAC	\$3.65	57
Mississippi	\$777	\$1/generic Rx; \$2/preferred brand Rx; \$3/other brand Rx	5 brand Rx/month	AWP – 12%	\$3.91	43
Missouri	\$824	\$0.50–\$2/Rx depending on drug cost		Lesser of AWP – 10.43%; SMAC, FUL, WAC + 10%	\$4.09	55
Montana	\$784	\$1–\$5/Rx depending on drug cost up to \$25 max/month			\$2.00 – \$4.70	
Nebraska	\$734	\$2/Rx	90-day supply	AWP – 12%	\$3.27 – \$5.00	55
Nevada	\$466	\$1/generic Rx; \$2/brand Rx	3 Rx/month; 34-day supply/ adult vitamins limited to pregnancy supplements; 30-day supply for chronic conditions	AWP – 15%	\$4.76	
New Hampshire	\$902	\$1/generic Rx; \$2/brand or compound Rx	30-day minimum supply up to 90-day maximum supply	AWP – 16%	\$1.75	50
New Jersey	\$778			AWP – 12.5%	\$3.73 – \$4.07	48

Exhibit 3-16 – Pharmacy Program Characteristics by State – cont'd

State	Expenditure per Beneficiary (net of rebates)	Co-Payment	Coverage Limitations	Reimbursement	Dispensing Fee	Generic Utilization Rate (%)
New Mexico	\$219	B – \$5/Rx with annual maximum across all services based on income; See state-specific FN	Rx must be generic unless physician overrides Mail-order dispensing permitted	AWP – 14%	\$3.65	
New York	\$873	\$0.50/generic Rx and OTC product; \$2/brand Rx	40 Rxs/year	AWP – 12.5% brand; AWP – 16.5% generic	\$3.50 brand; \$4.50 generic	43
North Carolina	\$871	\$1/generic Rx and covered OTC products; \$3/brand Rx	6 Rxs/month; Rx must be generic unless DAW	Lesser of AWP – 10%; SMAC or FUL	\$4.00 brand; \$5.60 generic	50
North Dakota	\$736	\$3/brand Rx	Adult vitamins limited to pregnancy supplements; smoking cessation products limited	Lesser of AWP – 10%; WAC + 12.5%, U&C, MAC, FUL	\$4.00 brand; \$5.60 generic	55
Ohio	\$809	\$3/Rx if not on preferred drug list		WAC + 9%	\$3.70	
Oklahoma	\$435	\$1–\$2/Rx depending on drug cost	6 Rxs/month including 3 brand Rxs; 7 additional generic Rxs/month for home- and community-based waiver participants; 34-day supply or 100 dosage units	AWP – 12%	Up to \$4.15	57
Oregon	\$402	A – \$2/generic Rx; \$3/brand Rx	15 Rxs/month; 100-day supply	Lesser of AWP – 15%, SMAC, FUL	\$3.50 retail; \$3.91 institution	61
Pennsylvania	\$431	\$1/Rx			\$4.00	47
Rhode Island	\$668			AWP – 10%	\$3.40	
South Carolina	\$564	\$3/Rx	AWP – 10% + \$4.05 dispensing fee for traditional pharmacies and \$3.15 dispensing fee for non-traditional pharmacies	AWP – 10%	\$4.05	
South Dakota	\$609	\$2/Rx	Adult vitamins limited to pregnancy supplements; OTC products not covered except insulin	AWP – 10.5%	\$4.75 – \$5.55	46
Tennessee	\$1,073	B1 – \$5/Rx; B2 – \$10/Rx		AWP – 13%	\$2.50	
Texas	\$525		3 Rxs/month	Lesser of AWP – 15%; WAC + 12%	\$5.14	

Exhibit 3-16 – Pharmacy Program Characteristics by State – cont'd

State	Expenditure per Beneficiary (net of rebates)	Co-Payment	Coverage Limitations	Reimbursement	Dispensing Fee	Generic Utilization Rate (%)
Utah	\$527	Varies depending on coverage group with preferential co-pays for generics; brand co-insurance of 25% for some groups or not covered if generic available	4 – 7 Rx per month, depending on coverage group	AWP – 15%	\$3.90 urban; \$4.40 rural	51
Vermont	\$810	\$1–\$3 depending on drug cost	Rxs for chronic conditions must be at least 30-day supply; adult vitamins limited to pregnancy supplements; lowest price generic equivalent product must be dispensed	AWP – 11.9%	\$4.25	
Virginia	\$688	\$1/generic Rx; \$3/brand Rx	Rx must be generic unless physician overrides	AWP – 10.25%	\$3.75	55
Washington	\$515			AWP – 14% brand; AWP – 50% generic with 5 or more labels	\$4.20 – \$5.20	60
West Virginia	\$927	\$0.50–\$3/Rx depending on drug cost	10 Rxs/month; 34-day supply; Only specified OTC products covered	AWP – 12%	\$3.90 + \$1.00 for compounds	
Wisconsin	\$675	\$1/generic Rx and \$3/brand Rx up to \$5/month; \$0.50/OTC drug	Most drugs limited to 34-day supply with 100-day supply for some	AWP – 13% brand; MAC on generic	\$4.38	
Wyoming	\$554	\$1/generic Rx; \$2/preferred brand Rx; \$3/non-preferred brand Rx		AWP – 11%	\$5.00	48

Average Generic Percentage = 52

Sources: - State Medicaid Outpatient Prescription Drug Policies: 2005 Update, Kaiser Commission
- Pharmaceutical Benefits Under State Medical Assistance Programs, 2004, National Pharmaceutical Council
- Individual State Medicaid Websites

The new co-insurance rules cannot be applied to all coverage groups. The list of exempted populations includes: children in a mandatory coverage group, foster care children, nursing home and hospice patients, women in the breast/cervical cancer coverage group and children receiving preventive services, persons receiving emergency care and women receiving pregnancy-related or family planning services.

The remaining enrollees include children in higher income families (including Denali KidCare enrollees, who already could be subjected to higher cost sharing), plus parents and HCBS waiver recipients. Together, these coverage groups account for about 30,000 of the program's 130,000 enrollees.

Patient Management

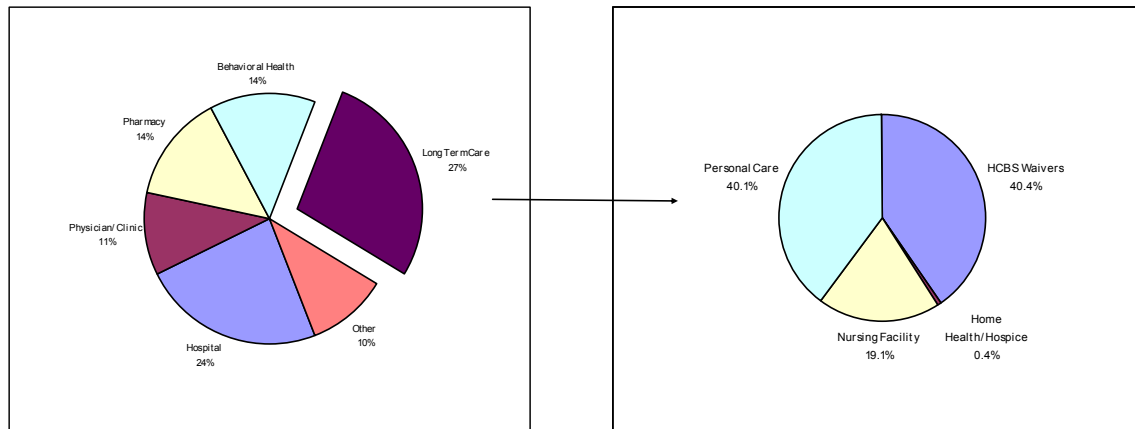
All 50 states have drug use review (DUR) programs in place, whereby program managers evaluate the use of medications by population, drug class or cost and use findings to initiate cost savings programs. DUR programs can also be used to increase prescriptions for those medications that have been shown to be beneficial when used by patients with certain conditions. Prescriber education programs can range from information on formulary medications to the targeting of prescribers who are outliers in the number of prescriptions they dispense.

Increasingly, states are moving beyond this type of post-hoc analysis to identify and target high-risk patients through disease management programs that involve coordination between the pharmacy unit and care/case management to improve health outcomes and reduce health expenditures within selected groups. Disease management is discussed more fully in the last chapter of the report.

Long-Term Care

Long-term care services accounted for just over one-quarter of Alaska Medicaid expenditures in state fiscal year 2005, with most of these dollars split evenly between HCBS waiver services (for the elderly, physically disabled and developmentally disabled) and Personal Care. Nursing Facilities made up about 20 percent of long-term care costs, with the remaining sliver split between Home Health and Hospice care.

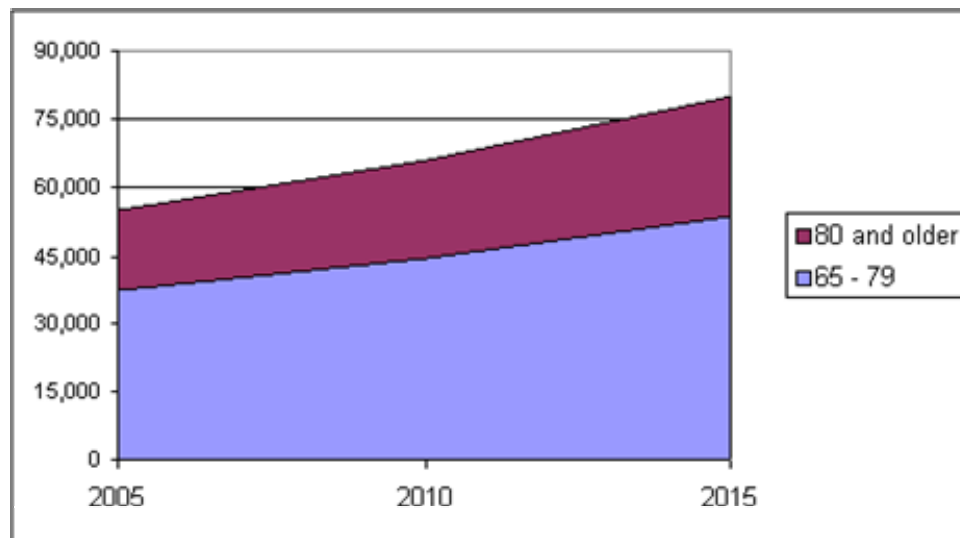
Exhibit 3-17 –Long-Term Care as Portion of Expenditures (2005)



Source: DHSS FY 2007 Budget Overview

Long-term care's share of the Medicaid program is projected to increase significantly in coming years, as the population ages and the prevalence of the frail elderly and persons with physical disabilities grows. The number of Alaskans ages 65 and older is projected to rise by nearly half, from 55,000 in 2005 to 80,000 in 2015; the segment ages 85 and older will jump from 17,000 to 26,000 (see exhibit 3-18 below). The developmentally disabled population will increase as well, as persons who in previous generations lived shortened life spans enjoy longevity closer to that of the general population.

Exhibit 3-18 – Elderly Population Growth in Alaska 2005 to 2015



Source: US Census Bureau

If current coverage and payment policies remain unchanged, and growth continues in a linear fashion, The Lewin Group/ECONorthwest study projects that long-term care expenditures will more than triple between 2005 and 2015, soaring from \$273 million to \$877 million (state and federal).³⁶ While there will be an increased need for long-term care that the state will be obligated to meet, accommodating the expenditure levels projected by Lewin/ECONorthwest would require either significant new revenue sources, major cuts in other services, or both.

A more realistic alternative would be to moderate the growth curve and ultimately strengthen the system, by taking actions that target the major sources of the problem. These sources differ somewhat between the elderly/physically disabled segment and the developmentally disabled, as discussed next.

Elderly/Physically Disabled

Alaska's utilization patterns and expenditures for the elderly/physically disabled do not conform to national norms, partly by design and partly by circumstance. Only 1.4 percent of elderly Alaskans reside in nursing homes, the lowest rate in the country and less than half the national average of 3.8 percent.³⁷

The low utilization rate is partly supply driven. In 2003, Alaska had the fewer than 800 certified nursing home beds – the least in the country. By comparison, Wyoming had had over 2,600 beds and Vermont more than 3,000.³⁸

Another factor is the Pioneer Home Network. While the Pioneer Homes are licensed as Assisted Living Facilities – a lower level of care than skilled nursing – they increasingly serve a population that in other states would reside in the Alzheimer's units of nursing facilities or in less costly, Alzheimer's-oriented community care settings. In 2005, a majority of Pioneer Home residents had Alzheimer's or another form of dementia and the percentage of residents requiring the highest of three levels of care offered in the facilities stood at 59 percent, up from just 25 percent in 1995.³⁹

³⁶ Source: *The Lewin Group, Inc. and ECONorthwest*, page 63

³⁷ Source: *StateHealthFacts* (2003)

³⁸ Source: *StateHealthFacts.org*

³⁹ Source: *DHSS FY 2007 Budget Overview*, page 23

Despite the low nursing facility utilization rate, and the state's still relatively small elderly population, Alaska actually ranked fifth highest in nursing facility expenditures per Medicaid enrollee⁴⁰ in 2003, at \$6,600, versus the national average of about \$4,200. Alaska has significantly higher than average per diem rates; in 2004, Alaska's average Medicaid per diem was \$323. By comparison, the rates in 35 other states for which data was available ranged from \$96 in Texas to \$186 dollars in Hawaii⁴¹ (see exhibit 3-19 for the complete listing).

Alaska's higher per diems are related to the state's higher cost of living, but also to the conscious decision to use nursing facility payments to subsidize institutions in rural communities that also serve as the sole inpatient provider for emergency acute care patients. Hospital-based and -related nursing facilities are costlier than free-standing facilities and in many states receive a premium to their rates as a result.

Alaska also makes available community alternatives for elderly and disabled persons who can be safely and cost-effectively served in these settings. The primary – and most controllable – mechanism for offering such services is through 1915c home- and community-based waivers. Under waivers, states have the ability to cap the number of enrollees, to use the care planning process to define and monitor (case manage) enrollee services and to apply a cost effectiveness test to these services.⁴²

Alaska has two waiver programs for the elderly and physically disabled – the Older Alaskans (OA) waiver and Alaskans with Physical Disabilities (APD) waiver. Exhibit 3-20 compares costs for Alaska's waivers to those in other states in 2002, the most recent year for which data is available. The data should be interpreted with caution, because waiver programs within the same category can differ significantly in terms of the actual composition of the enrolled population and mix of services offered. However, in 2002, costs in the OA and APD waivers were well within the norm. (Note that some states have combined waivers serving both groups, while others – including Alaska – separate them into distinct programs. Also

⁴⁰ Includes all Medicaid enrollees, not just long-term care recipients

⁴¹ Source: BDO Seidman, LLP

⁴² HCBS waiver programs must serve their enrollees at a cost no greater than would be incurred if the individuals were placed in nursing facilities. The average per diem becomes, in effect, the cap. Most states judge cost effectiveness at the program level, such that the average enrollee must be no costlier, though individual enrollees might exceed the limit. States have the flexibility, however, to judge each enrollee's cost effectiveness individually, and some states do apply this more stringent standard.

note that many states have waivers for persons with Traumatic Brain Injuries and Spinal Cord Injuries.⁴³)

Neither of Alaska's waivers are designed to serve persons with Alzheimer's or dementia. The waivers also offer limited in-home support services – chores and home delivered meals – making it difficult for many enrollees to remain safely in the residences without additional support from another source.

Increasingly, elderly and disabled beneficiaries are seeking in-home support through the Personal Care Attendant service option. Although up-front controls on the program have been tightened in the past year, Personal Care remains a state plan service to which Medicaid enrollees are entitled by law, which is not the case for waiver services. Not surprisingly, Personal Care expenditures have been increasing dramatically, rising 23 percent from state fiscal year 2004 to 2005.

⁴³ *In its report, Public Consulting Group recommends that Alaska establish a TBI/SCI waiver option. We did not evaluate provider capacity in the state for serving these groups, so do not include this among our recommendations.*

Exhibit 3-19 – Average Medicaid Nursing Facility Per Diems by State (2004)

State	2004 Rate
Alaska	\$323.00
Arizona	\$126.46
California	\$120.15
Colorado	\$144.82
Connecticut	\$168.40
Florida	\$148.84
Georgia	\$114.16
Hawaii	\$186.53
Indiana	\$106.87
Iowa	\$101.89
Kansas	\$104.93
Maryland	\$169.20
Massachusetts	\$165.96
Michigan	\$154.68
Minnesota	\$138.24
Missouri	\$104.90
Montana	\$125.70
Nebraska	\$118.84
Nevada	\$158.54
New Hampshire	\$162.40
New Jersey	\$166.27
New York	\$189.11
North Carolina	\$129.67
North Dakota	\$135.96
Ohio	\$158.09
Oklahoma	\$98.96
Oregon	\$142.47
Pennsylvania	\$173.97
South Dakota	\$97.65
Texas	\$95.99
Utah	\$133.70
Vermont	\$149.01
Virginia	\$114.01
Washington	\$141.53
West Virginia	\$158.64
Wisconsin	\$128.22

Source: BDO Seidman LLP

Exhibit 3-20 – HCBS Aged/Disabled per Recipient Waiver Costs by State (2002)

Individual State Expenditures by Waiver Type – 2002				
State	Aged	Physically Disabled	Aged & Disabled	TBI/SCI
Alabama	NA	\$17,237	\$5,401	NA
Alaska	\$15,608	\$14,248	NA	NA
Arizona	NA	NA	NA	NA
Arkansas	\$4,182	\$12,907	NA	NA
California	NA	\$89,580	\$2,883	NA
Colorado	NA	NA	\$5,726	\$16,828
Connecticut	NA	\$16,669	\$6,857	\$50,106
Delaware	\$4,752	NA	\$10,542	NA
District of Columbia	NA	NA	\$8,331	NA
Florida	NA	NA	\$5,645	\$12,078
Georgia	NA	NA	\$5,668	\$35,312
Hawaii	NA	NA	\$17,284	NA
Idaho	NA	NA	\$7,746	\$29,651
Illinois	\$3,263	\$6,416	\$9,345	\$8,335
Indiana	\$44,132	NA	\$7,515	\$22,898
Iowa	\$3,335	\$3,954	NA	\$9,762
Kansas	\$8,098	\$13,029	NA	\$23,056
Kentucky	NA	\$88,946	\$4,439	\$25,172
Louisiana	NA	\$14,785	\$6,770	NA
Maine	\$10,527	\$19,094	NA	NA
Maryland	\$11,295	\$5,592	NA	NA
Massachusetts	\$2,468	NA	NA	NA
Michigan	NA	NA	\$4,907	NA
Minnesota	\$6,237	\$8,215	NA	\$39,605
Mississippi	NA	\$12,075	\$7,928	\$8,850
Missouri	\$3,307	\$8,313	NA	NA
Montana	NA	NA	\$12,813	NA
Nebraska	NA	NA	\$8,506	\$25,731
Nevada	\$4,450	\$3,522	NA	NA
New Hampshire	\$7,561	NA	NA	\$80,009
New Jersey	NA	\$54,561	\$9,111	\$57,471
New Mexico	NA	NA	\$16,057	NA
New York	NA	NA	\$1,327	\$42,541
North Carolina	NA	NA	\$20,199	NA
North Dakota	NA	NA	\$10,186	\$24,406
Ohio	NA	\$23,385	\$6,509	NA
Oklahoma	NA	NA	\$5,235	NA
Oregon	NA	NA	\$7,548	NA
Pennsylvania	\$8,603	\$14,321	NA	NA
Rhode Island	\$5,699	\$22,048	\$7,710	NA
South Carolina	NA	\$18,032	\$5,487	\$20,602
South Dakota	\$3,038	\$19,218	NA	NA
Tennessee	NA	NA	\$8,562	NA
Texas	NA	\$37,945	\$10,741	NA
Utah	\$2,859	\$12,503	NA	\$18,679
Vermont	NA	NA	\$12,773	\$45,954
Virginia	\$298	\$109,879	\$9,338	NA
Washington	NA	NA	\$9,351	NA
West Virginia	NA	NA	\$9,289	NA
Wisconsin	NA	NA	\$11,359	\$59,578
Wyoming	\$5,642	NA	\$5,515	\$24,821

Source: StateHealthFacts.org

In 2005, Personal Care Attendant expenditures reached \$80 million, while the OA and APD waivers were barely half that amount, at \$42 million. Nationally, in 2003, the distribution between waivers and personal support services was close to 50-50.⁴⁴ That same year, even before the most recent growth in this service, Alaska ranked third highest among the 50 states in the share of its Medicaid long-term care budget devoted to Personal Care.

Having a large HCBS waiver program is not, in and of itself, a guarantee of cost effectiveness. States with well-managed programs share several characteristics: a strong pre-admission screening processes, cost-effective service alternatives within the menu of HCBS waiver options, and effective case management.⁴⁵

The pre-admission screen is essential to ensure that only persons who meet the long-term care level-of-need are approved to receive services. Every state has some type of pre-admission screening process, but to be most effective, a single, comprehensive screen should be administered to all persons seeking long-term care, regardless of their placement or ultimate package of services. The screen should have an objective determination method that tests whether an individual truly requires nursing facility placement or, absent some package of community-based care, would have to be admitted to a nursing facility.

In recent years, a growing number of states have adopted scored systems for determining long-term care eligibility. Applicants are assessed by trained clinicians (state employees, contractors or providers) and their completed assessments are converted to a numerical score, which is compared to a state-established threshold. Only those above the threshold qualify for Medicaid-reimbursed services.

Arizona, which piloted this approach in 1989, has one of the most rigorous screening systems, and highest denial rates, in the country. At the same time, Arizona's program serves nearly seven-in-ten long-term care recipients at home or in a community setting and the state is able to provide an appropriate set of services to all applicants who qualify. Often, states with weaker up-front controls are forced to provide some services to individuals who do not truly meet the long-term care standard, thereby diverting resources from those in greater need.

⁴⁴ Sources: DHSS FY Budget Overview, CMS MSIS Data

⁴⁵ Many of the recommendations outlined in this section also can be found in the Public Consulting Group (PCG) report, "Alaska Long-Term Care and Cost Study" issued earlier this year. Although PHPG reached its findings independently, we concur with the PCG report in the areas addressed here. Readers seeking more information on any of these topics are encouraged to read the PCG report, which solely addresses long-term care issues and therefore does so in greater detail.

In addition to determining eligibility, a comprehensive screen can be designed to provide the information necessary to guide development of a plan of care. At this stage, all services should fall under the planning process, including Personal Care Attendant.

Alaska uses a comprehensive instrument to collect information on nursing facility and waiver program applicants. The state also employs a modified scoring scheme which is less rigorous than Arizona's, but could readily be enhanced.

However, Alaska differs from many states in that it offers Personal Care Attendant services as a state plan option, thereby reducing Medicaid's ability to manage the benefit within a larger plan of care. As an alternative, Personal Care could be moved under the HCBS waiver option, thereby requiring elderly/physically disabled applicants to undergo the comprehensive screen and have this service allocated in conjunction with others during the care planning stage – assuming the applicant is found in need of long-term care. Personal Care service costs then could be controlled in the same manner as other HCBS services.⁴⁶ (As a lesser step, the state can strengthen care coordination between the waiver and Personal Care by making HCBS waiver case managers responsible for this activity – this is the action recommended by PCG.)

At the same time, the state should explore new, and less costly, care alternatives for the growing Alzheimer's/dementia group. A number of states provide Adult Foster Care (also known as Adult Family Care) as a relatively low-cost service option within their waiver programs. Adult Foster Care families can be certified to care for persons with mild to mid-stage dementia, coupled with some physical deficits, and provide the foster care service in their homes. This service is especially appropriate for small, rural communities that lack facility-based alternatives. (Alaska has the equivalent of AFC providers within its large Assisted Living Facility provider category. At a minimum, the state should move to tiered payment rates based on provider size, cost and complexity of care offered.)

One other initiative that Alaska should consider on the elderly/physically disabled side is a provider tax for nursing facilities. A provider tax, which must be broad-based (assessed on all residents, regardless of payer), would allow the state to leverage the higher per diems to its advantage. In its report, Public Consulting Group – which also makes this recommendation –

⁴⁶ *Because children are entitled to benefits under EPSDT that otherwise are not offered in the state, physicians could still authorize this service outside of a waiver. However, Personal Care is primarily furnished to adults.*

estimates that a six percent tax, the maximum allowed under federal law, would yield about \$2 million in new federal funds annually. The federal government has made an effort in the past year to lower the maximum tax rate to three percent, but even at that level the state would get a modest inflow of new federal dollars.

Developmentally Disabled (DD)

Alaska is one of just a handful of states to serve its developmentally disabled population completely outside of the institutional ICF/MR setting. At the same time, the state's DD waiver programs have extensive waiting lists. In July 2005, there were 1,200 individuals waiting for entry onto a waiver;⁴⁷ about half of this group received some services through grant programs funded with state dollars.⁴⁸ The total number served through grant dollars (including persons not on the waiting list) totaled about 3,200.⁴⁹

In 2004, Alaska's expenditures per DD waiver recipient were sixth highest in the country, at \$63,000, well above the national average of \$37,000 (see Exhibit 3-21 on the next page). In part, this number is a positive reflection of Alaska's reliance on community services or ICF/MR placements. Waiver dollars accounted for 72 percent of all Medicaid DD service expenditures in 2004, also well above the national average. In states like Mississippi, with low waiver costs, most dollars are spent on institutional care.

However, another factor pushing Alaska's costs higher appears to be the method used by DHSS to reimburse residential and day habilitation waiver providers. Payment rates –which are cost-based – are essentially negotiated on a provider-by-provider basis using self-reported and unaudited cost data. The data itself is not submitted in a uniform manner, but rather in whatever format the provider chooses. The result is high, and inconsistent, payment rates.

As an alternative, the state can and should: 1) collect cost information from providers using a uniform cost reporting tool; 2) audit this data; and 3) develop a single schedule of rates for use statewide. Once uniform rates are established, they can be updated, or rebased, with new cost data on a periodic basis (e.g., every four or five years). In “non-rebase” years, rates can be adjusted using an appropriate inflation adjuster.

⁴⁷ *The legislature did appropriate additional funds last year to reduce the waiting list (\$7 million state/federal), although at current spending levels, that amount would allow for only about 100 persons to move onto the waiver*

⁴⁸ *Ad Hoc Committee on the Developmental Disability Waitlist – Recommendations for Change (February, 2006)*

⁴⁹ *Source: DHSS FY 2007 Budget Overview*

Exhibit 3-21 – MR/DD Waiver Expenditures by State (2003)

	Alaska & United States	
	Waiver Cost Per Participant	Waiver Spending % of Total MR/DD Spending
United States	\$37,784	41%
Highest State	\$82,421	82%
Lowest State	\$11,934	3%
Alaska	\$63,172	72%
Alaska Rank	6 th	5 th

Individual State HCBS Waiver: Participants with MR/DD & Spending in FY 2004		
State	Waiver Cost Per Participant	Waiver Spending % of Total MR/DD Spending
Alabama	\$34,477	65%
Alaska	\$63,172	72%
Arizona	\$23,162	67%
Arkansas	\$20,546	19%
California	\$20,167	27%
Colorado	\$37,756	68%
Connecticut	\$62,093	37%
Delaware	\$82,421	43%
District of Columbia	\$11,934	3%
Florida	\$27,713	53%
Georgia	\$35,403	52%
Hawaii	\$32,797	64%
Idaho	\$35,669	23%
Illinois	\$32,341	22%
Indiana	\$42,192	46%
Iowa	\$24,058	30%
Kansas	\$33,011	53%
Kentucky	\$49,920	42%
Louisiana	\$61,004	36%
Maine	\$73,462	64%
Maryland	\$39,322	62%
Massachusetts	\$47,655	43%
Michigan	\$36,882	29%
Minnesota	\$55,987	65%
Mississippi	\$15,450	11%
Missouri	\$28,926	42%
Montana	\$27,377	50%
Nebraska	\$43,866	52%
Nevada	\$27,422	36%
New Hampshire	\$41,274	77%
New Jersey	\$43,192	29%
New Mexico	\$64,144	80%
New York	\$52,044	51%
North Carolina	\$43,631	25%
North Dakota	\$20,286	40%
Ohio	\$38,756	21%
Oklahoma	\$50,205	51%
Oregon	\$27,125	38%
Pennsylvania	\$43,459	50%
Rhode Island	\$77,052	82%
South Carolina	\$32,693	35%
South Dakota	\$27,800	62%
Tennessee	\$65,042	44%
Texas	\$38,591	22%
Utah	\$27,069	52%
Vermont	\$43,639	82%
Virginia	\$43,435	38%
Washington	\$27,141	41%
West Virginia	\$32,946	55%
Wisconsin	\$37,069	43%
Wyoming	\$42,841	68%

Source: The State of the States in Developmental Disabilities - 2005

Along with this reform, Alaska should explore opportunities for obtaining federal matching funds for services provided today through state-funded grants. In 2004, about 12 percent of MR/DD service expenditures went unmatched – for a total of about \$10 million; in state fiscal year 2005 the amount reached \$18 million.

This level of unmatched care is about average for the 50 states (see Exhibit 3-22), but a number of states, including New York, North Dakota and Vermont have succeeded in getting virtually all of their MR/DD services matched. By taking either of a couple of approaches, Alaska could reasonably expect to obtain federal match for the unmatched portion of its program, which would represent about \$5 million in new federal funds.

The “unmatched” MR/DD population includes persons on the DD waiver waiting lists, as well as persons not deemed eligible for the waiver under current pre-admission screening criteria. The first option for covering these groups would be to expand the size of the waiver and adjust eligibility criteria to include persons today deemed not eligible. This is the reverse of the approach recommended on the elderly/physically disabled side of the program, but is rational given that services already are being provided with state funds.⁵⁰

The other option would be to create a separate waiver, with benefits limited to those provided today with grant funds. This waiver could have distinct eligibility criteria and be structured in a manner to serve persons who otherwise would not expect to be enrolled onto one of the existing waivers. Its enrollment could be capped at a level commensurate with existing state funding, plus new federal dollars (or at current total levels, with federal dollars supplanting state funds).

Section 1115a Waiver

A final option for Alaska to consider would be a Section 1115a research and demonstration waiver specifically for long-term care, or as part of a full restructuring of the program, as outlined in Chapter 6. The advantage of a Section 1115a waiver is that the state could seek maximum flexibility to design benefit packages and define eligible populations within a federally-matched program. This could include offering limited long-term care benefits to persons in need of such services, but excluding some or all acute care benefits if these individuals do not otherwise qualify financially for Medicaid.

⁵⁰ PCG provides a lengthier discussion of this topic, and the manner in which Alaska's eligibility criteria could be relaxed. See *Alaska Long-Term Care and Cost Study*, page 50.

The state of Vermont implemented a similar waiver under Section 1115a in 2004 – 2005. Under its waiver, known as Choices for Care, low-income Vermonters assessed to be at future risk of long-term care placement are provided a limited set of home health and adult day care services. Unless an individual meets standard Medicaid financial eligibility standards, his/her acute care is funded solely through Medicare. Vermont, through the waiver, is able to cap enrollment in the program and adjust the cap, as funds permit, on a year-to-year basis.

Exhibit 3-22 – Matched and Unmatched Costs for MR/DD by State (2003)

Alaska & United States			
	Total MR/DD Spending	Unmatched State Funds	Unmatched % of Total Spending
United States	\$38,551,589,953	\$5,242,658,120	14%
Highest State	\$5,268,544,728	\$920,663,219	37%
Lowest State	\$84,782,969	\$0	0%
Alaska	\$84,782,969	\$10,131,049	12%
Alaska Rank	51 st	39 th	22 nd

Total MR/DD Spending & Unmatched State Funds			
State	Total MR/DD Spending	Unmatched State Funds	Unmatched % of Total Spending
Alabama	\$260,935,825	\$8,870,711	3%
Alaska	\$84,782,969	\$10,131,049	12%
Arizona	\$532,107,782	\$42,343,646	8%
Arkansas	\$326,574,119	\$6,863,771	2%
California	\$4,351,043,133	\$920,663,219	21%
Colorado	\$366,996,079	\$41,975,062	11%
Connecticut	\$1,080,887,103	\$399,777,448	37%
Delaware	\$120,220,231	\$37,992,582	32%
District of Columbia	\$187,549,443	\$26,634,156	14%
Florida	\$1,269,303,560	\$45,162,688	4%
Georgia	\$593,706,311	\$50,539,064	9%
Hawaii	\$102,154,406	\$12,021,581	12%
Idaho	\$234,153,757	\$5,465,862	2%
Illinois	\$1,419,161,862	\$304,729,432	21%
Indiana	\$834,056,132	\$80,935,822	10%
Iowa	\$570,393,705	\$101,561,322	18%
Kansas	\$391,530,526	\$22,328,587	6%
Kentucky	\$293,320,483	\$27,985,158	10%
Louisiana	\$763,401,237	\$54,190,856	7%
Maine	\$291,460,771	\$7,739,272	3%
Maryland	\$550,648,320	\$88,155,156	16%
Massachusetts	\$1,269,045,081	\$290,326,046	23%
Michigan	\$992,538,039	\$74,016,379	7%
Minnesota	\$1,253,786,314	\$49,725,549	4%
Mississippi	\$278,440,163	\$33,380,539	12%
Missouri	\$561,797,854	\$104,626,538	19%
Montana	\$109,590,140	\$10,785,535	10%
Nebraska	\$250,225,685	\$33,656,031	13%
Nevada	\$95,348,973	\$12,680,602	13%
New Hampshire	\$163,471,425	\$4,460,106	3%
New Jersey	\$1,244,590,091	\$395,351,043	32%
New Mexico	\$264,530,848	\$12,851,299	5%
New York	\$5,268,544,728	\$0	0%
North Carolina	\$1,071,997,785	\$171,349,541	16%
North Dakota	\$134,840,686	\$0	0%
Ohio	\$1,985,159,013	\$532,812,492	27%
Oklahoma	\$419,784,930	\$32,820,990	8%
Oregon	\$571,897,931	\$212,986,339	37%
Pennsylvania	\$2,147,504,832	\$282,802,425	13%
Rhode Island	\$267,095,191	\$6,954,142	3%
South Carolina	\$433,229,427	\$37,211,428	9%
South Dakota	\$110,205,892	\$5,034,275	5%
Tennessee	\$673,625,973	\$97,331,728	14%
Texas	\$1,467,564,404	\$214,758,607	15%
Utah	\$200,360,976	\$9,149,362	5%
Vermont	\$104,069,600	\$1,041,201	1%
Virginia	\$637,769,543	\$143,937,638	23%
Washington	\$697,615,646	\$69,950,137	10%
West Virginia	\$219,578,072	\$14,440,364	7%
Wisconsin	\$929,417,394	\$89,223,341	10%
Wyoming	\$103,595,561	\$2,918,000	3%

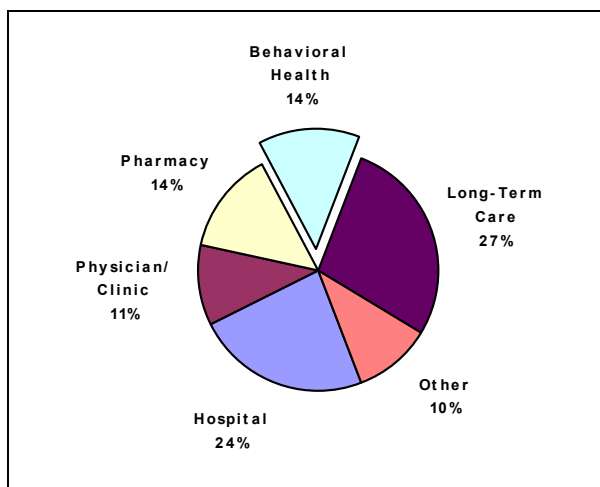
Source: State of the States in Developmental Disabilities: 2005

Behavioral Health

Behavioral health services, which include both mental health and substance abuse treatment, accounted for about 14 percent of Alaska Medicaid expenditures in state fiscal year 2005. Total expenditures amounted to about \$129 million, up from \$67 million in state fiscal year 2000.⁵¹

Over 80 percent of behavioral health dollars in 2005 went toward treating children. About 90 percent of the service dollars (for children and adults) was split almost evenly between residential psychiatric treatment centers (RPTCs) and general mental health, with inpatient psychiatric care making up the remaining portion. Very little is spent in the state on early intervention activities, to prevent or treat behavioral health problems at an initial stage. Instead, most spending is targeted to treatment of persons in crisis.

Exhibit 3-22– Behavioral Health as Portion of Expenditures (2005)



Source: DHSS FY 2007 Budget Overview

In fiscal year 2003, the most recent year for which national data is available, Alaska's expenditures for services in mental health facilities were highest in the nation, at \$480 per enrollee, compared to a national average of less than \$50.⁵² However, this figure is incomplete, because the Centers for Medicare and Medicaid Services do not separate-out behavioral health services from other provider categories (e.g., private physicians) to permit a true apples-to-apples comparison across states. Thus the gap between Alaska and the national average is likely less than suggested by this number, since Alaska relies heavily on

⁵¹ *Source: DHSS FY 2007 Budget Overview*

⁵² *Source: CMS MSIS Data*

community mental health centers for delivery of behavioral health. (Community mental health center providers report that their payment rates have been flat for 12 years and have fallen 62 percent in real terms in the intervening years.)

The rise in Medicaid spending appears to be due to multiple factors. First, the state has taken steps to secure federal funding under Medicaid for services previously funded only with grant dollars. This is a tactic we recommend for other segments of the Medicaid program, though preferably as a way to infuse net new dollars into the system. If Medicaid dollars purely supplant state funding – as appears to have been the case to a large extent within behavioral health – the program sees no benefit.

Instead, behavioral health’s budget has increasingly been absorbed by treatment costs for persons – particularly children and adolescents – in crisis, leaving fewer dollars for early intervention activities. Since the late 1990s, the state has seen a dramatic rise in the number of Medicaid-eligible adolescents admitted to RPTCs – 1,002 in SFY 2005 as compared to 222 in SFY 1998. And while a majority of placements in 1998 were to in-state facilities, by SFY 2004 the ratio was better than three-to-one in favor of out-of-state placements. Children and adolescents admitted to facilities in other states experience longer lengths of stay and suffer dislocation effects that could be avoided by treatment in their community (or the nearest large community in the state).⁵³

Alaska has taken significant steps to curb the rate of out-of-state placements through adoption of the “Bring the Kids Home” initiative, which seeks to add RPTC capacity in-state and divert children and adolescents to these beds. In SFY 2005, out-of-state admissions dropped from 749 to 711, while in-state admissions rose from 216 to 291. Total RPTC days, which had been growing at an average annual rate of about 20,000 between SFY 1998 and 2004, increased by a more modest 8,000 between 2004 and 2005.

The state’s shift from out-of-state to in-state providers is important, although it still will leave Alaska dependent on in-patient care at a time when many states are placing a greater emphasis on community-based, early intervention services. As savings are realized from the Bring the Kids Home initiative, the state should consider re-directing a portion to preventive and early intervention services targeted at Alaska’s youth.

⁵³ Source: *Bring the Kids Home Annual Report (December 2005)*

Covered Services – Findings & Recommendations

Alaska's program looks very much like the other 49 states, in terms of the optional Medicaid services offered in addition to those mandated by federal law. Partly because of the state's demographics, optional services actually account for less of the program in Alaska than in the country as a whole.

Alaska's program is expensive, however, when compared to other states on a per beneficiary basis. The state ranks near the top in each of the major service categories, even though utilization in many areas – hospital and pharmacy for example – is not high. Total expenditures grew at double digit rates in the first part of the decade and, while that growth has abated in the past year, it is expected to reach near double digit levels again before the decade is out.

Every state in the past several years has taken steps to rein in costs, with activities divided between incremental measures – such as cuts in provider payments or eligibility standards – and structural reform through Section 1115a waivers. Alaska has taken action on the incremental side, for example by freezing Pioneer Home payment rates, creating a preferred drug list and prior authorization process for pharmacy and undertaking more aggressive program integrity activities.

There are additional incremental opportunities available to the state to moderate program growth and to secure additional federal funds. These include:

- Expanding the prior authorization process for prescription drugs to include additional drug classes
- Adopting a tiered payment system for pharmacies that continues to reimburse critical access providers at higher rates, while adopting lower rates for other pharmacies (e.g., chain drug stores in urban areas)
- Implementing a comprehensive pre-admission screening instrument for the elderly/physically disabled portion of long-term care, and moving Personal Care services from the state plan to a waiver program
- Adding new waiver service options targeted toward persons with Alzheimer's/dementia, as a lower-cost alternative to Pioneer Home placement

- Extending Medicaid coverage to persons receiving state-funded DD services, either by enlarging the current waiver or creating a new waiver with services matching those available through the state-only program
- Directing resources toward preventive and early intervention behavioral health services to counter the current emphasis on costlier inpatient treatment

At a structural level, the state should consider pursuing these and other reforms under the umbrella of a Section 1115a research and demonstration waiver, as discussed in Chapter 6. Such a waiver would give greater flexibility to state policymakers and allow the program to operate in a manner best suited to Alaska's needs, while capping the state's financial exposure at a level negotiated and agreed to by the federal government.

CHAPTER 4 – TRIBAL HEALTH

Key Findings

- ✓ American Indians and Alaska Natives (AI/ANs) represent 40 percent of Alaska's Medicaid population. Tribal health is a \$740 million delivery system, responsible for the majority of health care services provided to American Indians and Alaska Natives
- ✓ Medicaid expenditures for services provided within the tribal health system are funded by 100 percent federal funds, while services provided outside the tribal health system are funded at the regular federal matching rate. Medicaid expenditures for services provided to American Indians and Alaska Natives by non-tribal providers totaled \$220 million in 2005, of which \$93 was state matching funds
- ✓ The tribal health system faces significant fiscal challenges, as IHS funding has been increasing at an annual rate well below the actual health care inflation rate
- ✓ The health status of Alaska Natives and American Indians is significantly worse than that of the population overall. AI/ANs have much higher death rates from tuberculosis and chronic conditions such as diabetes. Alaska Natives also face high rates of disease – such as infections and respiratory illnesses – traceable to poor public health infrastructure
- ✓ Alaska's Native population is overwhelmingly rural, with nearly six-in-ten living in villages with fewer than 300 residents. Given the isolation of many rural villages, access to community-based care is both essential and challenging
- ✓ Although Alaska's Native population is younger on average than the state's general population, the need for long-term care among AI/ANs is rising and will increase significantly in coming years. If the tribal system is unable to address AI/AN long-term care needs, the responsibility will fall to non-tribal providers, requiring additional state resources
- ✓ The State has realistic options for supporting the tribal health system's goal of operating independently and meeting the health needs of AI/ANs, thereby increasing the share of services funded to AI/AN Medicaid beneficiaries at the 100 percent match rate

Introduction

Native Alaskans account for nearly four-in-ten Medicaid beneficiaries, by far the largest Native American segment of any state Medicaid program. In fiscal year 2005, the program included 52,000 American Indian/Alaska Native (AI/AN) enrollees, an increase of 3.6 percent from the previous year. The number actually receiving services grew by 5.2 percent.

Overview of the Tribal Health System

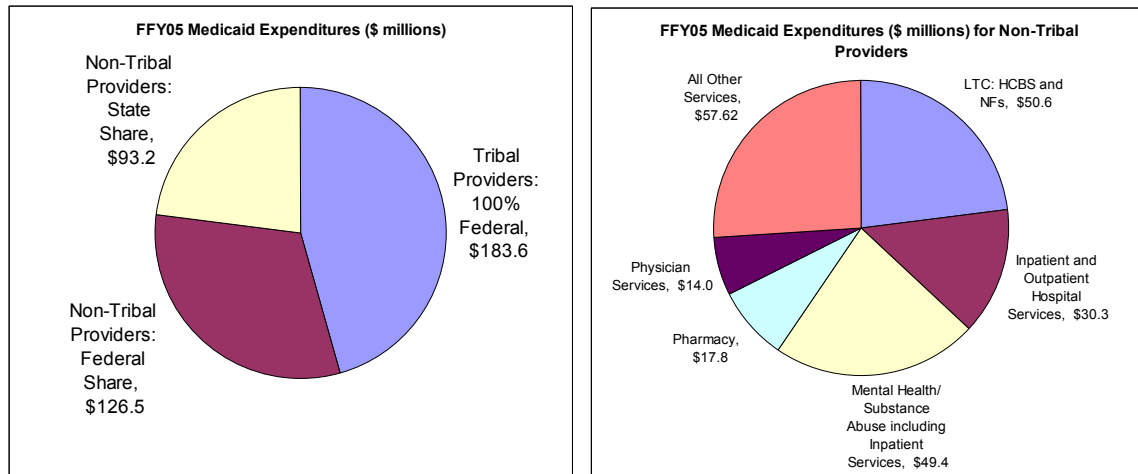
Alaska tribes govern and operate the tribal health system under a statewide compact. Tribes may operate independently or may designate a single entity to operate the health care delivery system. Federal law (PL93-638) authorized tribal providers to take over facilities of the Indian Health Service (IHS); these “638” providers develop annual funding agreements with IHS. The Indian Health Service provides approximately \$440 million in funding annually, representing about 60 percent of the tribal system’s total annual budget.

Various treaties, judicial opinions, federal statutes, executive orders and other measures establish an obligation on the part of the federal government to provide health care to tribal members. For this reason, Medicaid payments to tribal providers are paid with 100 percent federal funds.

However, IHS, unlike Medicaid or Medicare, is not an entitlement under federal statute, and is therefore subject to the annual federal budget process. IHS funding for the Alaska tribal health system increases one to two percent per year, while the tribal system’s expenses have been growing at a rate of approximately eight to nine percent per year.

In federal fiscal year 2005, Medicaid payments to tribal providers, which are 100 percent federally funded, amounted to approximately \$180 million. Medicaid paid another \$220 million at the regular federal matching rate for services furnished by non-tribal providers to AI/AN beneficiaries. Most of the non-tribal provider expenditures went for three services: inpatient hospital, behavioral health and long-term care (see Exhibit 4-1 on the following page).

Exhibit 4-1 – AI/AN Healthcare Medicaid Funding Sources



Source: DHSS Tribal Health Management Office

The low rate of IHS funding increases has placed strains on a system already coping with increased service needs and limited infrastructure. Alaska Natives and American Indians as a group face significantly greater health risks than the general population. The AI/AN death rate for tuberculosis is 6.5 times higher than for Americans as a whole. The death rate is 5.2 times higher for pneumonia/influenza and is 4.2 times higher for diabetes.⁵⁴ Alaska Tribal Health System Epidemiologists project that incidence of diabetes, heart disease and cancer will grow over the next decade, as the AI/AN population increases in size overall and the segment age 55 and older comes to make-up a larger percentage of the total.

As AI/AN health care needs grow faster than IHS funding, tribal providers are increasingly reliant on access to Medicaid (at 100 percent federal funding) for support. From a fiscal standpoint, it is in the state's interest to build stronger relationships with tribal providers, but in discussions with PHPG, these providers identified specific challenges related to Medicaid funding and their reliance upon it. These challenges include:

- Medicaid eligibility processing
- Enrollment of providers in Medicaid
- Medicaid claims submission
- Lack of program flexibility
- Lack of funding to build infrastructure

⁵⁴ Source: Alaska Native Tribal Health Consortium

Medicaid Eligibility Processing

Because Native Alaskans access tribal health services regardless of whether they are eligible for Medicaid, it is often difficult to enroll individuals in the Medicaid program. Further, the recently enacted Federal Deficit Reduction Act tightens documentation requirements for Medicaid eligibility and may present cultural barriers for AI/AN beneficiaries who lack birth certificates.

Medicaid and tribal health providers have sought opportunities to address administrative barriers. For example, DHSS – in coordination with the Alaska Native Tribal Health Consortium (ANTHC) – stationed Denali KidCare enrollment workers at the Alaska Native Medical Center in order to target eligible Alaska Native children.

Further opportunities to facilitate Medicaid eligibility processing for AI/ANs within current administrative rules should be exploited where feasible. At the same time, the state, in coordination with tribal representatives, should explore reforming and streamlining eligibility criteria and processing for AI/ANs as part of a broader reform initiative enacted under federal waiver authority. If made part of the larger waiver initiative described later in the chapter, such streamlining could significantly reduce the administrative burden for beneficiaries, providers and the state, without requiring additional state resources for reimbursement of claims costs.

Provider Enrollment & Claims Payment

Tribal providers describe the Medicaid provider enrollment process as challenging. Tribal providers also experience a claim denial rate of 24.4 percent, versus 17.6 percent for non-tribal providers. The most common reason code for denial of tribal providers' Medicaid claims is: "Recipient Not Eligible on Dates of Service".

One administrator expressed frustration in communicating with the state to resolve outstanding claims issues. The state should consider designation of a single point-of-contact within the MMIS function to assist tribal providers with both provider enrollment and claims processing issues.

Lack of Program Flexibility

As a result of health professional shortages, particularly in the remote areas of the state, providers must identify creative approaches for meeting the particular needs of their communities. Examples of ideas to improve health care delivery include the following:

- Medicaid coverage for services provided by individuals trained in behavioral or oral health care and supervised by an appropriately-licensed or credentialed professional
- Medicaid coverage of consultations between physicians and mid-level health care practitioners
- Medicaid reimbursement for provider travel expenses, particularly when it is more cost-effective for one provider to travel for the purpose of treating several patients, rather than transporting these patients to the provider's primary location
- Medicaid reimbursement of a broad array of community-based long-term care services

Lack of Funding to Build Long-Term Care Infrastructure

As the Native Alaskan population, like the greater Alaskan population continues to age, there will be different pressures placed on the IHS system. It is estimated that by 2030, elders will make up 12.2 percent of the AI/AN population.⁵⁵ A Census Bureau study in 1999 found that 63 percent of AI/AN adults ages 65 and older had a disability.

It would be in the state's interest, from both a financial and quality of service perspective, to actively participate in establishing greater capacity among tribal providers to furnish long-term care – both institutional and community-based. This should occur as part of a larger effort to support the tribal health care system, as discussed below.

⁵⁵ Mcellan, T and Rafelito, A "Key Issues Facing American Indian and Alaska Native Elderly with Medicaid Reform." Medicaid Roundtable. August 31, 2005.

Support for the Alaska Tribal Health System

The tribal health system is a large, sovereign program. Because it operates within the culture of each community, and strives to respond to the needs of its members, it is best positioned to meet the health care needs of Native Alaskans, given the appropriate supports.

And because tribal providers receive 100 percent federal Medicaid funding, Alaska would realize state savings if Medicaid services currently delivered at non-tribal sites were instead provided by 638 providers. For example, the Alaska Medicaid program spends approximately \$19 million for non-tribal nursing facility services provided to AI/ANs, of which approximately \$8 million is state matching funds. If Alaska were to provide financial support for development of tribal health long-term capacity, the potential state savings could be significant.

Exhibit 4-2 below presents a basic example of the potential state savings resulting from the construction of a single, tribally-operated nursing facility using state dollars.

Exhibit 4-2 – Tribal Nursing Facility Example

	State	Federal	Total
<i>Nursing Facility Expenditures: Non-Tribal Provider</i>			
Cost per nursing facility day	\$170	\$230	\$400
Total annual Medicaid expenditures to serve 50 clients	\$3,096,660	\$4,203,340	\$7,300,000
Ten-year Medicaid expenditures (8% annual growth)	\$44,859,959	\$60,891,947	\$105,751,906
<i>Investment in Tribal Provider Infrastructure</i>			
State investment	\$8,000,000		
(equal to estimated construction cost of 60-bed facility)	---	\$7,300,000	\$7,300,000
Ten-year Medicaid expenditures (census = 50)	---	\$105,751,906	\$105,751,906
Total Expenditures	\$8,000,000	\$105,751,906	\$105,751,906
<i>Potential State Savings Over Ten Years: Single Facility</i>	\$36,859,959		

Broad-Based Reform

Any conversion of non-tribal services to tribal health care will bring an incremental benefit to the state. The state also may wish to explore a complete transformation of the existing Medicaid financing arrangement.

Specifically, Alaska could pursue re-organization of the tribal health care delivery system as a managed care entity. Under this arrangement, which would continue to resemble the current system from an operational standpoint, Medicaid funding to the tribal health plan would be based on the full range of Medicaid-eligible services for Medicaid-eligible Native Alaskans. Subject to negotiation with the federal government, such payments could potentially be 100 percent federally funded, thereby removing most or all of the state's current expenditures.

In exchange for payment, the tribal health entity would be responsible for ensuring access and delivery of all Medicaid-eligible services, including sub-contracting with non-tribal providers (who could still be permitted to bill and receive payment through the MMIS). The tribal health entity, in return, would have the opportunity to re-invest monies into health promotion, disease prevention and culturally-appropriate community-based care initiatives intended over the long term to improve access to services in rural communities, while lowering costs.

The potential benefits and challenges of this arrangement are discussed further in Chapter 6.

CHAPTER 5 – MEDICAID ADMINISTRATION

Key Findings

- ✓ Alaska's Medicaid administrative costs on a per eligible basis are much higher than most states', though this is at least partly due to the program's small enrollment base and geographic challenges
- ✓ The program appears to meet CMS accuracy standards for eligibility determination, but faces challenges in preparing for new federal payment accuracy audits scheduled to begin in 2008
- ✓ The Department's MMIS Request for Proposal outlines an aggressive design, development and implementation schedule that should be closely monitored by the legislature
- ✓ The Department's recently-issued draft regulations for covered services comply with federal law and regulations, with only a few areas for potential follow-up by DHSS identified

Introduction

The Department of Health and Social Services (DHSS) is Alaska's Single State Agency for Medicaid. As a component of the broader evaluation of the Medicaid program, PHPG conducted a high-level review of DHSS's organizational structure and administrative costs. This section contains findings from the review.

The chapter begins by providing a brief background on DHSS's organizational structure, which was significantly altered in 2003, and comparing DHSS administrative costs to those of its sister agencies in other states. This is followed by an examination of DHSS activities in two key areas – Medicaid eligibility determination and program integrity/claims payment. The claims payment review is followed by a discussion of DHSS's ongoing efforts to procure a new MMIS contractor.

The chapter also includes results from PHPG's examination of the department's recently-issued revised regulations for covered services. It concludes with a brief summary of findings and recommendations.

Department of Health & Social Services

As a general rule, the 50 states have taken one of two approaches in organizing the administrative component of their Medicaid programs. A number – including Alaska – have opted for what are sometimes referred to as “super agencies” – single departments that house all of the operational components of the program under one Secretary or Commissioner. Usually, these agencies include public health, social welfare and child protective services in addition to Medicaid. The remaining states break-out Medicaid's core health service delivery function and place it in a stand alone agency. The Health Care Services Division with DHSS has the approximate scope of responsibility assigned to stand alone agencies in states with that structure.

The primary purpose of the super agency approach is to encourage collaboration across functional areas in the interest of greater efficiency and better services. Many program areas – such as behavioral health – have both Medicaid and non-Medicaid funding sources and recipient groups. In states where Medicaid is a stand alone agency, behavioral health may be

split across two departments – Medicaid and a distinct mental health agency. In super agencies, both components are brought together, at least in theory.

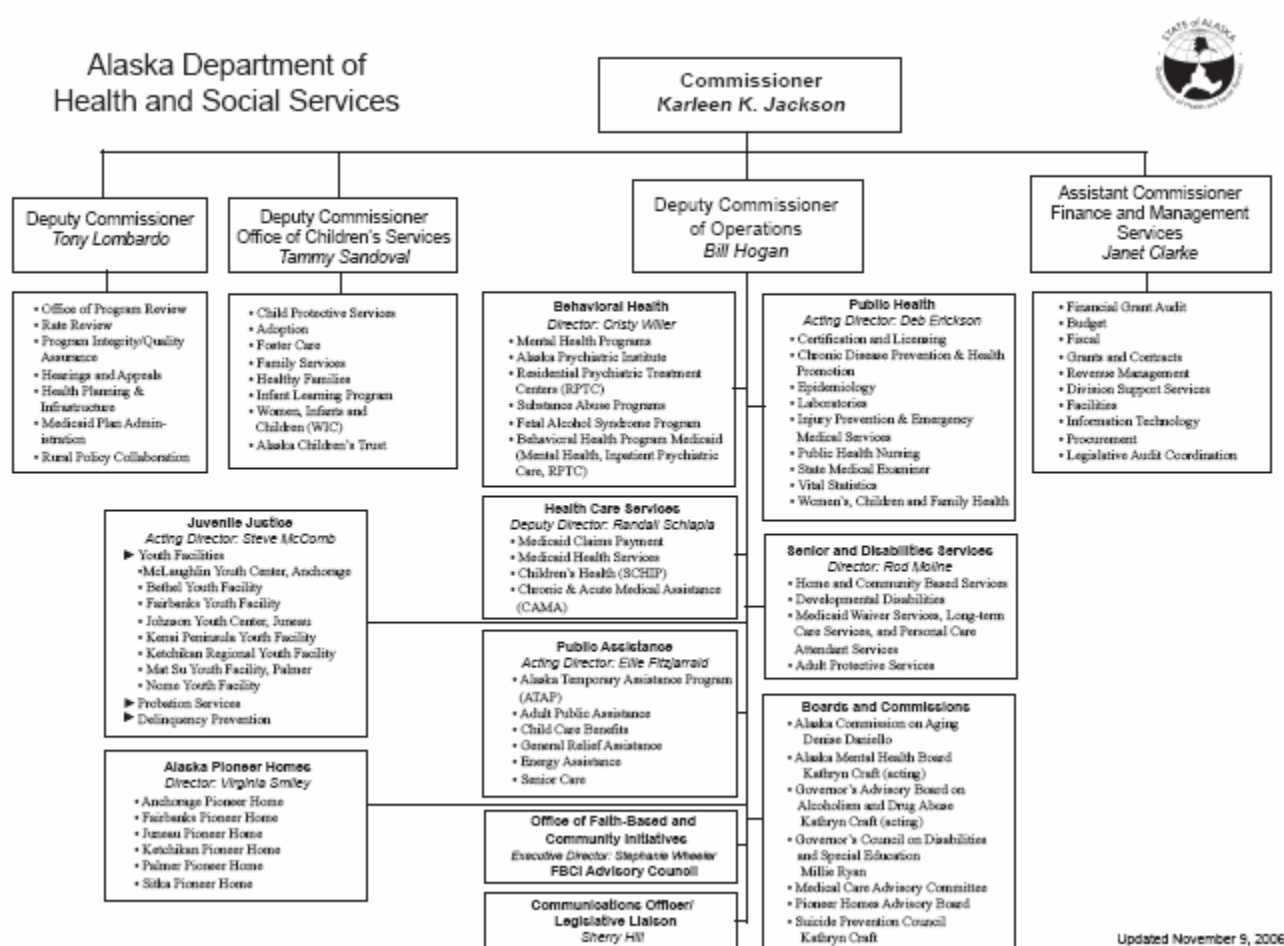
Department of Health and Social Services was reorganized in 2003 with the goal of improving program administration within the super agency structure, by aligning policy and budgeting staff responsible for a particular program component. In discussions with senior and middle managers, the general consensus was that, more than two years after much of the reorganization occurred, personnel are becoming more comfortable with their new roles and the “dislocation” effects of the reorganization are fading.

DHSS today contains four major divisions with responsibility for portions of the Medicaid program. They are:

- *Division of Behavioral Health* – oversees mental health and substance abuse services and includes functions that were formerly housed in: the Division of Alcoholism and Drug Abuse, Mental Health and Developmental Disabilities, and the Office of Fetal Alcohol Syndrome
- *Division of Health Care Services* – contains core Medicaid services, including hospitals, physician/clinic, pharmacy, dental transportation and other acute care services. The division also finances and manages programs from women’s and children’s health. It now includes functions that were formerly housed in the Division of Medical Assistance and the Maternal and Child Family Health section of the Division of Public Health.
- *Division of Senior & Disability Services* – manages Medicaid’s long-term care programs and includes functions that were formerly housed in the Department of Administration, the Division of Developmental Disabilities, and the Division of Medical Assistance.
- *Division of Public Assistance* – responsible for Medicaid and Denali KidCare eligibility determination and includes functions that were formerly in the Division of Public Health and the Department of Education and Early Development.

Exhibit 5-1 on the next page contains a DHSS organizational chart showing these four divisions and others with less direct relevance to Medicaid.

Exhibit 5-1 – DHSS Organizational Chart



50-State Analysis: How Does Alaska Compare?

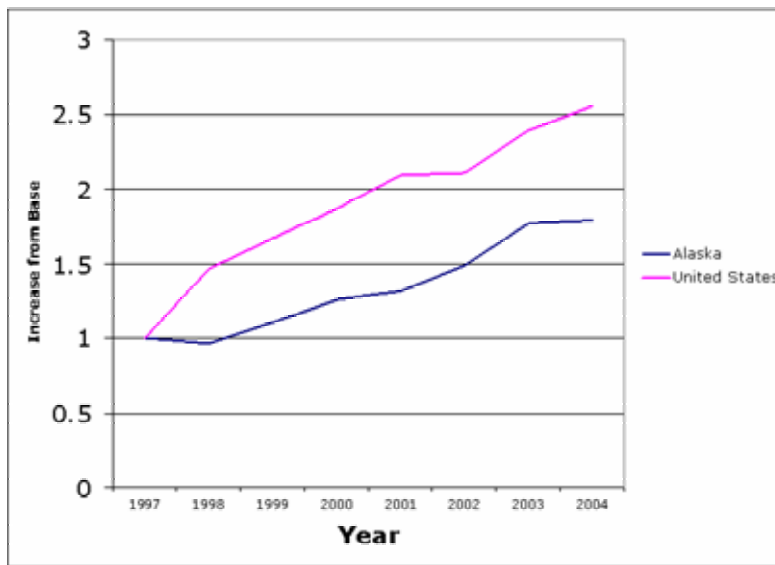
The most recent comparable data on Medicaid administrative costs is for federal fiscal year 2003. At that time, prior to the reorganization, Alaska's Medicaid administrative costs, on a per eligible basis stood at \$504, versus a national average of \$224. Adjusting for Alaska's higher cost of living (using the same methodology described earlier) results in a per enrollee cost of \$403, moving the state down to third place. Exhibit 5-3 presents cost data for all 50 states.

Another way to measure the relative size of a state's administrative costs is to examine administrative expenditures as a percentage of total Medicaid expenditures (administration +

medical claims). By this yardstick, Alaska still ranked in the top ten, at 6.8 percent, but was much closer to the national average of about five percent.

In addition, Alaska's administrative spending actually grew at a slower pace than did costs nationally from 1997 – 2004. If costs in 1997 equaled 1.00, Alaska by 2004 had reached 1.79 while costs nationally were up to 2.76 (see Exhibit 5-2 below).

Exhibit 5-2 – Administrative Cost Growth 1997 – 2004, Alaska & US



Source: Centers for Medicare and Medicaid Services, CMS-64 and 37 Reports

While Alaska's administrative costs are relatively high, they are not necessarily a product of inefficiency. Due to Alaska's large size and sparse population, recipients are spread out across large geographic areas and require more facilities and personnel to serve the same number of individuals than is the case in more compact states.

Alaska also is unable to gain economies of scale available to states with larger populations. No matter what a program's size, certain functions – with substantial fixed costs – must be performed. For example, every program operates a Medicaid Management Information System, and the cost and complexity of these systems does not vary significantly depending on a state's enrollment.

Exhibit 5-3 – Admin Expenditures (2003)

	Alaska & United States	
	Admin Costs per Eligible	Admin as % of Total
United States	\$244	4.9%
Highest State	\$529	8.8%
Lowest State	\$130	2.5%
Alaska	\$504	6.8%
Alaska Rank	2nd	9th

Individual State Expenditures – 2003		
State	Admin Costs per Eligible	Admin as % of Total
Alabama	\$143	2.8%
Alaska	\$504	6.8%
Arizona	\$162	3.7%
Arkansas	\$165	4.2%
California	\$205	8.5%
Colorado	\$234	4.2%
Connecticut	\$231	3.7%
Delaware	\$295	5.6%
Florida	\$193	4.3%
Georgia	\$232	5.0%
Hawaii	\$323	6.4%
Idaho	\$329	7.0%
Illinois	\$319	5.4%
Indiana	\$215	4.7%
Iowa	\$218	3.6%
Kansas	\$278	5.6%
Kentucky	\$132	2.5%
Louisiana	\$153	3.2%
Maine	\$210	4.0%
Maryland	\$365	5.5%
Massachusetts	\$306	4.1%
Michigan	\$317	4.3%
Minnesota	\$382	4.8%
Mississippi	\$130	2.5%
Missouri	\$219	4.3%
Montana	\$274	4.7%
Nebraska	\$266	7.1%
Nevada	\$287	6.0%
New Hampshire	\$485	4.8%
New Jersey	\$529	4.1%
New Mexico	\$138	4.7%
New York	\$254	3.1%
North Carolina	\$208	4.4%
North Dakota	\$275	4.3%
Ohio	\$186	3.2%
Oklahoma	\$254	5.6%
Oregon	\$387	8.5%
Pennsylvania	\$350	5.0%
Rhode Island	\$383	4.7%
South Carolina	\$138	3.6%
South Dakota	\$146	3.2%
Tennessee	\$317	7.2%
Texas	\$205	4.1%
Utah	\$284	6.1%
Vermont	\$395	7.8%
Virginia	\$308	6.0%
Washington	\$395	8.8%
West Virginia	\$243	4.6%
Wisconsin	\$188	4.1%
Wyoming	\$336	8.3%

Source: CMS Medicaid Budget and Expenditure System

Medicaid Eligibility Determination

The Division of Public Assistance (DPA) within DHSS is responsible for determining eligibility for Family Medicaid, Denali KidCare and Adult Public Assistance Medicaid.⁵⁶ DPA operates 17 full-service offices directly and contracts on a “fee agent” basis with partner offices in very rural/remote communities.

After a person has been initially determined eligible for Medicaid, DPA encourages re-certification via mail. Eligibility for Family Medicaid must be recertified every six months, while disabled persons are recertified annually. Both cycles are within the norm for state Medicaid; a few states certify Family Medicaid beneficiaries more frequently (up to monthly), but this can result in persons moving on and off Medicaid (often due to paperwork delays) to such an extent that care is disrupted. A number of states recertify Family Medicaid beneficiaries annually, which provides for greater continuity of care, but increases program costs.

The federal government requires that states monitor and report on the accuracy of their Medicaid eligibility determinations through the Medicaid Eligibility Quality Control process, or “MEQC”. Reviewers select a sample of processed applications and review them to determine if they were correctly processed and if the determination occurred timely.

In 2005, Alaska performed focused studies in two areas – determination of retroactive eligibility for Denali KidCare applicants and Medicaid eligibility determination for Adult Public Assistance applicants. In both studies, about 94 percent of the cases were found to have been properly processed; errors were identified in the remaining six percent, resulting in additional staff training on applicable policies. Alaska’s error rate is higher than the CMS target rate of three percent, but is not out of line with the performance in most states.

DHSS is in the final stage of adopting re-codified eligibility regulations for Medicaid. This effort follows the development of revised eligibility regulations for the state’s long-term care waiver program. Prior to adoption of those revised regulations, appellants challenging eligibility denials prevailed about 80 percent of the time. The revised waiver regulations clarified the eligibility criteria, resulting in an appellant success rate today that is closer to 20 percent. While Family Medicaid and other non-long-term care categories have not

⁵⁶ SSI determinations are made by the Social Security Administration. Eligibility for long-term care requires a separate clinical review, as discussed in the next chapter.

experienced the same level of appeals as did long-term care, the state expects the revised regulations to have a positive effect on reducing errors and limiting the ability of eligibility workers to improvise.

Program Integrity & Provider Payment Errors

In February 2003, a legislative audit report was released that dealt with the internal controls over Medicaid payments. At that time, Medicaid relied on a variety of methods to ensure proper payments were being made. These included: edits within the Medicaid Management Information System (e.g., to check for double billings); prior authorization requirements for selected services; ClaimCheck automated billing audits (to check for inappropriate unbundling of services); and on-site medical record reviews.

The legislative audit found that despite the widespread program integrity responsibilities – or because of them – the overall level of oversight was weak, with controls either being circumvented not being used in the first place. The HCBS waiver program suffered from a lack of well-designed controls.

Several actions were taken in response. First, DHSS began an extensive re-codification of service regulations, starting with HCBS services, to bring greater clarity to payment rules and prevent providers from side-stepping limits on service units. DHSS also dedicated resources to Program Integrity and Analysis functions and contracted with the firm of Myers and Stauffer to conduct targeted audits of providers and personal care agencies, with a mission to identify possible under- and over-payments.

In July, 2006, DHSS gave notice of its intention to review and strength rules related to program integrity. These changes include:⁵⁷

- “Clearly defining the review of and recoupment of overpayments from providers by the department”
- “Clearly defining the provider appeal process related to review and recoupment of overpayments”

⁵⁷ PHPG was informed that Program Integrity is developing a broad Quality Assurance plan for the department, but it was not completed at the time this report was prepared.

- “Further stating what must be included in the notice of appeal and the notice of sanction”
- “Establishment of new sections that clearly define program integrity, fiscal audit, quality assurance, statistical sampling, utilization review, and appeal rights related to program integrity”

DHSS’s actions are timely, given activities at the federal level. In 2002, Congress passed the Improper Payments Information Act (IPIA) which requires federal agencies to review programs that are at a high risk for improper payments. In response, CMS developed a program that assesses error rates on a state-level basis, and then determines a national error acceptance rate. States that have error rates significantly in excess of the national rate may face disallowances and be ordered to refund federal matching dollars. The Office of Management and Budget defines significant erroneous payments as annual erroneous payments exceeding both 2.5 percent of program payments and \$10 million.

CMS is in the process of pilot testing the audit method that will be employed nationally to calculate state-specific payment error rates. This method – known as the Payment Error Rate Measurement, or “PERM” – will be applied both to Medicaid and SCHIP. The results of a precursor pilot conducted in 2004 (Payment Accuracy Measurement) are not encouraging; CMS in that study found an average error rate of nearly seven percent.

Alaska is scheduled for its first PERM audit beginning in January 2008. The Health Care Services Division within DHSS has identified three program areas as priorities for improvement before the audit occurs – therapies, dental and durable medical equipment.⁵⁸ Over the course of the audit, DHSS will submit 200-300 randomly-selected claims each month and these claims will be subject to a complete financial and medical audit by CMS’s PERM contractor.

The PERM audit in Alaska will have an extra layer of complexity, as it will overlap with DHSS’s efforts to bring a new MMIS contractor on board. During the months leading up to the audit’s start, the legislature is advised to exercise its oversight capacity to monitor DHSS activities to prepare for the audit, particularly in regard to the three priority program areas.

⁵⁸ *DHSS identified these areas through an internal audit. PHPG requested a copy of the audit report but it was not made available until mid-November, as this document was being finalized. It therefore has not been reviewed.*

Medicaid Management Information System (MMIS)

Alaska has contracted with the First Health Services Corporation since 1987 to operate a Medicaid Management Information System. First Health also oversees the MMIS in Nevada and Virginia, and is the third largest contractor nationally after EDS, which is in 18 states and ACS, which is in 12 (15 states operate their systems in-house).⁵⁹ In 2003, DHSS awarded a new contract to First Health with the intent of significantly upgrading the MMIS and expanding its functionality. DHSS subsequently moved to terminate First Health's contract and in early November the Department issued a new Request for Proposals from potential successors to First Health (which remains in place until a new contractor comes on board).

PHPG reviewed the MMIS RFP and identified a number of areas for potential follow-up or monitoring by the legislature as the process unfolds. Due to time constraints, we did not review these questions/comments with DHSS prior to issuing our report.

- Take over and DDI – DHSS has included an option under which the new contractor will take over operation of the current MMIS. It appears – though it is not entirely clear in the RFP – that any such takeover would overlap with the new contractor's design, development and implementation of the new MMIS. While it is not unreasonable to include a takeover task, given the state's desire to finalize First Health's departure, it would be very difficult for a new vendor to do both things simultaneously.
- The implementation schedule is aggressive, which is understandable given the time lost during the past three years. However, it appears that DHSS will have to review and approve two, three and sometimes four deliverables per month to keep the project on schedule. This is very aggressive and is of potential concern unless DHSS has sufficient internal and contracted (consulting) resources to manage such a workload.
- Budget – The proposed budget for DDI activities is \$30 million, which may be low based on recent experience in other states and the onsite time required of the vendor in the RFP.
- Performance Bond – The performance bond requirement (20 percent of DDI costs) may be low given the risk associated with the project

⁵⁹ Source: CMS Fiscal Agent Contractor Status Report (February 2006)

Regulatory Comparison

The Medicaid program (Title XIX of the Social Security Act, as amended) is jointly financed by the federal and state governments and administered by the states. Within broad federal rules, each state decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures.

Title XIX provides for the designation of a Single State Agency to administer the Medicaid program, and the Alaska Department of Health and Social Services fills that function for the Alaska. As the Single State Agency required by federal statute to administer the Medicaid program, DHSS was required to submit a state plan to the federal government for approval. The state plan is a comprehensive written statement describing the nature and scope of Alaska's Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of Title XIX and other applicable federal authorities.

In order to help ensure compliance and consistency, Alaska's state plan and its proposed state regulations for covered services were compared with the federal regulations which implement Title XIX. Specifically, Alaska's state plan, state regulations 7 AAC 100.001 through 100.102.990, and Title 42 of the Code of Federal Regulations (CFR) were consulted. This section concludes with specific recommendations to eliminate possible inconsistencies.

Methodology & Approach

To start, the above-referenced state regulations were analyzed and a review conducted to ascertain whether or not a corollary exists in the federal code. When a corollary was identified, the language of the state regulation and federal regulation were compared and a determination as to whether the state regulation conformed to the federal regulation was made.

Citations to the state regulation, the applicable federal regulation, and any inconsistency perceived were entered into a matrix, which is included as Appendix B to the report. Subsequently, specific sections of Title 42 of the CFR were reviewed and attempted to ascertain whether or not a corollary exists in the state regulations or the state plan. Similarly, when corollaries were identified, the language of the three authorities was compared, a determination as to conformity was made, and the applicable citations and the perceived

inconsistencies were included in the matrix. Alaska publications (e.g. member handbooks), which have been adopted by reference into Alaska's regulations, were consulted as appropriate.

Blank cells in the spreadsheets indicate that a corollary could not be found, as opposed to the fact that the particular citation was passed over. The blanks are not of major consequence considering a corresponding state regulation for each and every federal regulation is unnecessary. It is much more important, rather, that the state regulations that do exist conform to federal regulations, and that the state plan contain the information the federal regulations require that it contain.

Findings

There were very few instances in which state authorities appeared to be inconsistent with federal authority. For example, of the 481 state regulations reviewed, only 8 potential inconsistencies were detected, for an "error rate" of a mere 1.66%. As such, it appears that Alaska performed a very thorough review of applicable federal authorities when it sought to repeal existing state regulations and propose revised language.

The seven inconsistencies are shown below. These have not been shared with DHSS in advance of the report being issued:

7 AAC 100.424

This state regulation relates to Katie Beckett/TEFRA Medicaid eligibility. In order for a child to qualify as eligible under 42 CFR § 435.225, he or she, among other requirements, must meet the level of care (LOC) associated with a hospital, skilled nursing facility (SNF), or intermediate care facility (ICF). Inclusion of an inpatient psychiatric facility LOC in the state regulation is questionable, considering such a facility is separately defined in federal regulation.

7 AAC 102.042

This state regulation, applicable to the appeal rights of sanctioned providers, does not appear broad enough. Encompassed therein are avenues of appeal associated with denial and termination, however the state may wish to specifically address non-renewal as is the case with 42 CFR § 431.153.

7 AAC 102.106

The state regulation concerning the receipt of Medicaid services out-of-state appear stricter than the federal corollary found at 42 CFR § 431.52. For example, the federal regulations specify that payment is available if: 1) services are needed because of a medical emergency; or 2) the recipient's health would be endangered if he or she were required to travel to his state of residence. The state regulation, however, provides that payment is available if medical services are needed due to a medical emergency and the recipient's health would be endangered if the recipient were required to travel to Alaska.

7 AAC 102.240

The state requirements for the enrollment of “hearing service” providers appear to be inconsistent with applicable federal requirements. 42 CFR § 440.110 specifies, for example, that under certain circumstances a provider may qualify for reimbursement if he or she is completing the required practical experience necessary for certification, as opposed to being fully licensed as required by the state regulation.

7 AAC 102.464

No federal authority was identified which permits a state to predicate Medicaid coverage upon an individual possessing third-party insurance as set forth in this state regulation.

7 AAC 102.590

42 CFR § 440.120 specifies that the services of an ophthalmologist or optometrist are reimbursable but the state includes the services of an optician in this state regulation as well. The state may wish to confirm that this type of provider qualifies for reimbursement under the umbrella of durable medical equipment (DME).

7 AAC 102.700

No federal regulation was found which permits a state to extend the period of time a provider has to submit a claim beyond a year as is contemplated by this state regulation. 42 CFR § 447.45(d)(1) appears to specifically prohibit such a practice.

Administrative Findings & Recommendations

Alaska's administrative costs are high in comparison to other states, but this is at least partly due to the challenge of operating a program with a small number of beneficiaries spread over a large area. DHSS's administrative expenditures also have grown more slowly than the national average over the past decade.

More importantly, DHSS faces two significant, and related, operational challenges in the next several years. First, the Department will fall under the PERM audit process in 2008, at which time any significant weaknesses in its program integrity function and payment controls could result in disallowances from the federal government. At the same time, DHSS will be managing the design, development and implementation of a new MMIS. When in place, this MMIS (if it meets RFP specifications) promises to significantly enhance DHSS's information management capacity. However, the roll-out schedule for the MMIS is very ambitious and will require substantial investment in time and resources from DHSS and its consultants. The legislature, for its part, should use the deliverable schedule outlined in the RFP as a basis for tracking progress toward implementation and identifying, at an early stage, any risks for delays.

CHAPTER 6 – RECOMMENDATIONS FOR REFORM

Introduction

The Alaska Medicaid program has experienced significant growth over the last five years, with total program expenditures nearly doubling between 2000 and 2005. While the growth rate has recently slowed, DHSS's own long-term expenditure forecast anticipates significant spending increases over the next decade, partly propelled by Alaska's aging population. Fiscal pressures will compel the state to make difficult choices regarding program design.

Alaska is hardly alone in facing this challenge. Every state in recent years – including Alaska – has taken incremental steps to constrain program growth, as discussed in Chapter 3.

In our review of the Alaska program, PHPG identified additional incremental opportunities to either better control spending or increase federal financial participation. These recommendations – which are addressed in chapters 2 – 4, can be implemented within the current program structure. And while they would have a positive impact, they will not fundamentally affect the state's ability to control the program's future trend lines, which are to a large degree being driven by federal regulations with respect to covered populations and services, and state demographics.

However, over the past five years the federal government has shown a greater willingness to provide states with the flexibility to restructure their programs and adopt new financing and health care delivery methods intended to bring greater control over program budgets. The government has done so in two ways – through the Deficit Reduction Act of 2005 (DRA) and the Section 1115a waiver process.

The DRA permits states to introduce higher beneficiary cost-sharing in the form of premiums and co-payments, and to restructure benefits for certain enrolled groups. The Section 1115a waiver option has been used by several states in the past few years – most notably Florida and Vermont – to take further steps to restructure their programs.

For example, Vermont (as discussed later in the chapter) negotiated a global cap on its program, locking-in federal financial participation up to a pre-defined level. The state also received federal match for services that previously had been funded with state dollars only

and was granted the flexibility to change coverage conditions for optional Medicaid groups without, in most cases, filing state plan amendments or seeking federal approval.

Development of a Comprehensive Reform Plan

Alaska has recognized the importance of program planning and evaluation, as evidenced by recent studies to forecast program expenditures and assess the long-term care system. These studies indicate that program change is inevitable; the program as it exists today is not financially sustainable over the long term. The logical next step is to develop a comprehensive approach for program reform.

Based on our review of the Alaska Medicaid program and discussions with legislative staff, department staff and other stakeholders, we have identified a series of broad program reform objectives. If Alaska elects to pursue comprehensive program reform, its approach should address these objectives:

- Ensure the best use of public resources to meet Alaskans' health needs
- Ensure that the program is culturally appropriate and recognizes Alaska's unique demography
- Ensure that the program is fiscally sustainable for the long-term
- Encourage preventive care and early intervention
- Promote access to quality care
- Ensure that the state has the necessary tools to quickly respond to client needs, changes in the delivery system and fiscal constraints

Thoughtful planning is not easy; program managers frequently are engaged in responding to current fiscal and programmatic crises. Development of a comprehensive, long-term approach will ensure that Alaska achieves its objectives and develops the health care delivery system it wants.

Moving Beyond Traditional Cost Containment

As discussed in Chapter 3, traditional Medicaid cost containment actions typically fall into five categories:

- Modification of eligibility criteria to control program enrollment

- Reduction or elimination of covered services
- Controls to reduce service utilization
- Reductions in provider reimbursement
- Increased enrollee cost-sharing, including premiums and co-payments

Traditional cost containment actions may be unavoidable in the face of short-term fiscal shortfalls. However, actions taken to control costs in one area often have unintended consequences in other service areas. For example:

- Restricting access to Home- and Community-Based waiver services may increase expenditures for state plan services such as personal care and home health
- Restricting access to ambulatory behavioral health care may increase expenditures for more costly institutional care

As a result, policymakers seek out opportunities to contain program expenditures while adhering to programmatic objectives. The “Bring the Kids Home” initiative is an example of this approach; an opportunity to realize savings through improvements to the health care delivery system.

States have developed broad-based, innovative approaches to control program expenditures while adhering to the programmatic objective of providing coverage to low-income citizens. Exhibit 6-1 compares traditional cost containment activities with examples of more innovative reforms that could prove beneficial to Alaska. The individual reforms are discussed in the next sections of the chapter.

Exhibit 6-1 – Approaches to Cost Containment

Program Area	Traditional Approaches	Innovative Approaches
<i>Eligibility</i>	<ul style="list-style-type: none">▪ Eliminate optional eligibility groups or tighten eligibility standards▪ Tighten eligibility criteria for specialized programs (e.g., behavioral health, long-term care, developmental services)	<ul style="list-style-type: none">▪ Expand eligibility to individuals who will benefit from early intervention and preventive care
<i>Covered Services</i>	<ul style="list-style-type: none">▪ Eliminate optional services▪ Establish service limits (e.g., number of covered visits, prescriptions)	<ul style="list-style-type: none">▪ Expand covered services to include state-funded programs and less-costly providers
<i>Provider Reimbursement</i>	<ul style="list-style-type: none">▪ Reduce payment rates▪ Pharmacy purchasing pools	<ul style="list-style-type: none">▪ Implement pay-for-performance measures
<i>Service Utilization</i>	<ul style="list-style-type: none">▪ Establish prior authorization criteria▪ Establish preferred drug lists	<ul style="list-style-type: none">▪ Disease management▪ Managed health care approaches
<i>Medicaid Financing</i>	<ul style="list-style-type: none">▪ Enrollee Contributions▪ Provider Contributions	<ul style="list-style-type: none">▪ Premium assistance programs▪ Health Savings Accounts▪ Financing of health care for American Indians and Alaska Natives

Many of the initiatives can be implemented without Section 1115a Demonstration authority, in some cases because of new flexibility granted under DRA. However some could only be implemented under a waiver, as discussed below.

Expansion of Medicaid-Covered Populations & Services

Description/Objectives

States historically have sought opportunities to maximize Medicaid funding and reduce the need for state dollars. Examples of these initiatives include:

- Billing Medicaid for case management functions provided by various human services departments
- Billing Medicaid for school-based health services
- Conversion of programs previously funded by grants to Medicaid-eligible services

While these programs generally have proven successful in securing federal support and reducing state funding commitments, they can have unintended consequences. The risks include:

- Creating incentives within public delivery systems to serve only Medicaid patients

- Creating incentives within public delivery systems to provide only those service types that are eligible for Medicaid reimbursement
- Diverting staff resources from care delivery to recordkeeping/billing activities

Through comprehensive reform planning, Alaska may be able to identify potential sources of federal Medicaid funding while simultaneously addressing some of issues arising out of previous Medicaid conversions.

As an example, Alaska's conversion of community mental health services from grant-based funding to Medicaid fee-for-service (FFS) funding has made it difficult for community mental health providers to serve low-income clients. If Alaska were to expand eligibility for low-income individuals in need of the mental health services, by creating a special coverage group for that purpose, advantages could include the following:

- Existing state-only funding could be matched with federal dollars, thereby reducing state funding requirements, creating additional funding for services, or a combination of state savings and program expansion
- Early intervention could produce positive health outcomes, thus reducing the need for more costly services
- Individuals not receiving timely and appropriate treatment are more likely to become eligible for Medicaid; early intervention could reduce the incidence of disability and job loss
- Alaska could establish an outcomes-based financing system, enabling providers greater flexibility in determining the appropriate types of services, rather than being restricted to a defined set of covered services

States have expanded eligibility and benefits as a means to reduce state spending on health care. Opportunities to reduce state funding requirements through Medicaid expansions generally fall into the following categories:

- Coverage of alternative, less costly service types may reduce expenditures for currently covered Medicaid services

- Coverage of early intervention and preventive services may eliminate or delay the need for more costly services
- Opportunities may exist to obtain Medicaid funding for services that are currently covered with (unmatched) state dollars

As part of its comprehensive planning process, Alaska should identify and evaluate the following opportunities:

- All state-funded health services, including the Chronic and Acute Medical Assistance (CAMA) program, long-term care, mental health services, substance abuse treatment services, and developmental services
- Cost-effective alternatives to current benefits, such as community behavioral health aides, community-based alternatives to inpatient treatment, reimbursement of providers' travel costs, and providers' telephonic consultations
- Alaskans who currently are underserved and are at risk of requiring more costly and intensive services

Best Practices

Several states have secured funding flexibility under Section 1115a Demonstrations. While many states in the 1990s used the demonstration waiver option to expand coverage to uninsured, low-income adults, more recently states have acted to secure matching funds for existing programs already being funded with state dollars. For example:

- New York enrolled its General Assistance population under its Demonstration, a program previously funded by state and local dollars
- Illinois received authority to obtain federal matching funds for its state-funded pharmacy assistance program
- Utah offered a primary care benefit to previously ineligible residents, funded by a reduction in benefits for optional Medicaid populations
- Oregon enrolled a state-funded coverage group in its Demonstration

- Vermont established a case rate system for the funding of mental health services provided to individuals with severe and persistent mental illnesses, creating additional flexibility to expand the range of available services
- Vermont also expanded eligibility for its long-term care program to individuals at risk of requiring nursing home placement in the near future

Federal Regulatory Authority

States have obtained federal authority to expand services or eligibility for specialized populations through the Section 1115a Demonstration process. Under an 1115a Demonstration, States apply to the Centers for Medicare and Medicaid Services (CMS) for approval to operate a program that does not conform to all federal Medicaid requirements. The purpose of these waivers is to examine whether there are more effective approaches for the delivery of health care.

In exchange for authority to operate aspects of the program differently, Alaska must agree that total program costs will not exceed the costs to the federal government in absence of the Demonstration. This Demonstration requirement, referred to as the “budget neutrality” agreement, establishes a five-year limit on program expenditures. The limit would be determined through analysis of Alaska’s historical expenditures and projected growth rates. The budget neutrality agreement would place Alaska at risk for program expenditures in excess of the budget neutrality limit. Federal matching funds are not available for expenditures above the five-year limit and the state is solely responsible for these expenditures.

Section 1115a Demonstrations offer states a great deal of flexibility to pursue innovative approaches for funding health care, but this flexibility is coupled with the obligation to control overall program expenditures to a pre-defined limit.

Potential Program Savings

Potential savings resulting from the conversion of state-funded services to Medicaid-eligible services are relatively straight-forward, with total state funding reduced by the now-available federal share. However, the state may elect to re-invest some or all of the federal funds in program expansion.

The potential impact of expanding eligibility to individuals at risk of becoming Medicaid-eligible and requiring more costly treatment is difficult to project and savings may not be realized for two to three years. Frequently, states perceive these types of expansions as an investment toward “bending the curve” on future program growth.

Pay-for-Performance

Description/Objectives

Both public and private payers have begun seeking alternative approaches for reimbursing providers that focus on quality and outcomes, rather than the amount and types of services delivered. In this spirit, a number of state Medicaid programs have begun developing pay-for-performance initiatives. For its part, CMS operates a “Physician Group Demonstration Practice” that is designed to evaluate the impact of Medicare reimbursement for physician services based on a series of outcome measures.

The current fee-for-service system provides reimbursement to providers for defined types of procedures, at established rates. In some cases, financial incentives exist to provide additional care or more complex care. Under the pay-for-performance model, provider reimbursement is based on outcomes, resulting in a greater emphasis on preventive services, early intervention, and care coordination.

Traditionally, Medicaid pay-for-performance concepts were associated with traditional managed care through HMOs. States are now evaluating options for service providers, including hospitals, physicians, and nursing facilities.

A pay-for-performance model creates the opportunity for providers to have greater flexibility regarding treatment and service delivery. As an example, Alaska might consider a pay-for-performance model for community mental health services, whereby payment could be tied to defined outcomes measures, such as inpatient hospitalization rates.

Pay-for-performance also presents the opportunity for more flexible funding streams; for example, community mental health providers could “share” the savings with state for reduced out-of-state placements.

Best Practices

- Pay-for-performance concepts often are part of primary care case management (PCCM) programs, discussed later in this chapter. The Maine and Oklahoma PCCM programs both offer financial incentives to physicians for meeting targeted performance benchmarks. For example, Oklahoma physicians who exceed the state's defined target for childhood preventive visit and immunization rates, share in a bonus pool that, in previous years, has made awards of more than \$10,000 per doctor.
- Massachusetts is developing a program to provide financial incentives for doctors and hospitals to meet certain quality targets. Pennsylvania developed pay-for-performance measures for nursing facility services.
- Pennsylvania also implemented a pilot program to offer financial incentives to hospitals for achieving clinical outcomes, such as reduced re-admission rates, as well as operational measures, such as participating in a medication safety program and development of medication error reporting systems.

Federal Regulatory Authority

Federal Medicaid regulations require reimbursement to be based on providers' costs and the Medicaid only reimburse providers for covered services. Therefore, performance-based payment approaches would need to be related to the cost of providing covered services.

Broad reform options that promote flexible service delivery and enable providers to access "savings" derived from reduced utilization of other covered services may be require federal waiver authority.

Potential Program Savings

Potential savings for pay-for-performance depend on the scope of the plan. As an example, a pay-performance plan that offers enhanced reimbursement for nursing facilities meeting certain survey benchmarks will not produce any savings, but potentially improves quality of care. Incentives that reimburse providers for reduced inpatient utilization, however, could generate significant savings and help to facilitate the development of community-based alternatives to inpatient care.

Disease Management/Care Coordination

Description/Objectives

Care coordination and disease management programs are both methods used increasingly by state Medicaid programs to improve the health status of enrollees, while potentially lowering program costs.

Disease management programs focus on improved delivery of care for specific, high-cost conditions. Care coordination programs focus on managing the care of high-cost patients (regardless of diagnosis).

Patients with chronic disease can account for up to 50 percent of a state's Medicaid census, with some studies suggesting that the figure is as high as 60 percent.⁶⁰ Treating these patients can place a substantial burden on Medicaid program expenditures. However, even with these significantly higher costs, treatment levels are often less than optimal. A recent national study found that only 45 percent of diabetic patients get the care they need, and only 25 percent receive recommended testing.⁶¹

Disease management programs typically rely on a multi-faceted approach to treating individuals with certain diseases, interdisciplinary clinical teams, continual use of performance indicators to assess patient improvement and providing physicians and other health professionals with information and cost-effective technology to improve outcomes.⁶² CMS has identified five core characteristics of true disease management programs:

- Identification of patients and matching the intervention with need
- Support for adherence to evidence-based medical practice guidelines, including providing medical treatment guidelines to physicians and other providers, and providing support services to assist the physician in monitoring the patient
- Service designed to enhance patient management, and adherence to an individualized treatment plan

⁶⁰ Williams, C "Medicaid Disease Management: Issues and Promises." *Kaiser Commission on Medicaid and the Uninsured*. (September, 2004)

⁶¹ *Ibid*

⁶² "Medicaid Disease Management and Health Outcomes." *National Pharmaceutical Council*. www.dnnow.org

- Routine reporting and feedback loops
- Collection and analysis of process and outcome measures⁶³

Most of the 18 existing Medicaid disease management programs focus on three main chronic conditions: asthma, diabetes, and congestive heart failure. Other conditions addressed in one or more states include: high-risk pregnancies, end stage renal disease (kidney failure), HIV/AIDs, hemophilia, hypertension, sickle cell anemia, pain management, cardiovascular disease, immunizations, depression, cancer, chronic obstructive pulmonary disease and ADHD. Diseases are selected on the basis of prevalence, cost and where increased patient self-care could improve quality and reduce the cost of treating individuals with these diseases.

Once a state decides to implement a disease management model, and the target conditions have been selected, patients must be contacted, behavior and treatment plans developed based on practice guidelines and patient assessments, and resources committed to enhancing physician-patient communication in support of the process.

Best Practices

States frequently contract with private disease management companies to implement and operate their programs, at least in the initial stages. Contractors may be reimbursed a flat, annual amount, a per capita amount, or an amount based on demonstrated program savings.

- Indiana designed its model around a hybrid system, keeping overall control of the program in-state while outsourcing its component parts
- North Carolina has built a community-based approach, which revolves around enrolling PCCM providers. Each provider has an assigned case manager, who works with eligible patients and is able to act as an intermediary fostering communication between the two parties

⁶³ CMS State Medical Director Letter #04-002. (February 25, 2004).

Federal Regulatory Authority

Disease management programs are considered to be a medical service, rather than an administrative cost, and are therefore eligible for federal Medicaid matching funds at the regular FMAP. However, to qualify the program must have a direct service component.

Programs that do not qualify for the regular FMAP can still claim administrative match at the 50 percent rate. In these programs, there is no direct contact with beneficiaries, but rather promotion of evidence-based guidelines, improving communication between physician and patient, and utilization feedback.

In order to further reduce state expenditures, pharmaceutical manufacturers have been known to supplement the cost of the programs. Such assistance is considered a supplemental rebate allowable under section 1927 of the SSA, and therefore must be reported to offset the amount of federal funds claimed.

Disease management plans can be implemented without a waiver, so long as the program is completely voluntary. To do so, only a state plan amendment would be required. However, to implement a program that targets just a geographic area or specific Medicaid enrollees, a 1915b “Statewideness” waiver would be required.

Potential Program Savings

At this stage, data on the performance of disease management programs is preliminary, though promising.

In Virginia, where physicians were given feedback about the number of ER visits for their patients, patients of physicians who received notification had a 41 percent decline in ER visits over the study period.⁶⁴

In Colorado, the state found that asthmatics enrolled in the disease management program experienced 15 percent lower costs than a control group

Washington State reported saving \$250,000 from treating asthmatics in the program’s first years. Washington also reported saving \$900,000 treating diabetics the first year, \$375,000 treating congestive heart failure, and \$680,000 treating end state renal disease.⁶⁵

⁶⁴ Williams, C “Medicaid Disease Management: Issues and Promises.” *Kaiser Commission on Medicaid and the Uninsured*. (September, 2004).

Managed Health Care Approaches

Description/Objectives

In the mid-1990s, more than half of the country's state Medicaid programs looked to traditional, HMO-style managed care as an approach to improve access to health care and quality, while achieving program savings. Although Medicaid managed care plans continue to operate in parts of most states, a number elected either to discontinue their programs or to restrict HMOs to urban centers, while testing physician-centered approaches in rural areas.

Some states have examined the private HMO model to identify aspects of managed care that could be implemented within the existing Medicaid program; recent growth in care coordination and disease management programs is an example of states' adoption of managed care principles.

Many rural states have looked to primary care case management (PCCM) programs as an option for improving health care delivery for Medicaid enrollees. The basic objectives of a PCCM model include the following:

- Improve access to primary care
- Improve coordination of services
- Reduce emergency room utilization for non-urgent care
- Provide a mechanism to (modestly) supplement physician fees

A basic PCCM program assigns each enrollee to a primary care provider (PCP) who serves as his or her "medical home". The PCP typically is paid a "case management" fee, ranging from \$2.00 to \$5.00 per enrollee, per month, in exchange for meeting basic contractual obligations, such as:

- Ensuring timely access to physician care
- Providing 24-hour on-call coverage
- Authorizing specialist referrals

Other managed care concepts adopted by state Medicaid programs include member service and 24-hour nurse advice lines. The Member Service line frequently is operated and staffed by a third-party vendor; the same vendor may be responsible for program enrollment

⁶⁵ *Ibid*

functions, such as distribution of member handbooks and assistance with selecting a PCP. The Nurse Advice line relieves some of the burden on PCPs to provide 24-hour coverage and provides an opportunity for enrollees to receive basic health advice and education. Some PCCM programs incorporate other innovative approaches, such as physician participation in disease management programs and pay-for-performance incentives for participating PCPs.

Best Practices

Many states have embraced the concept of operating their Medicaid programs like managed health care delivery systems. Their PCCM programs are part of an overall managed healthcare strategy. Innovative PCCM features of other state programs include the following:

- Oklahoma pays participating PCPs under a capitated model for the provision of all primary care and some in-office laboratory and X-ray procedures. Oklahoma offers performance incentive payments to PCPs who meet certain benchmarks, such as childhood immunization targets.
- Massachusetts reimburses PCPs an enhanced fee of \$10 each time the PCP provides certain primary care procedures. The enhanced fee is intended to encourage the provision of primary care and promote care management.
- North Carolina PCPs participate in the state's disease management/care coordination program. Two monthly case management fees are made for certain enrollees – one payment to the PCP and another to a community partner responsible for care coordination activities.
- Maine established performance incentive pools that are distributed to participating PCPs for meeting certain program goals, including reduced emergency room utilization.
- Massachusetts assessed its PCCM program using private HMO accreditation standards.

The State of Vermont's Medicaid department operates the entire Medicaid program, except long-term care, as a managed care organization (MCO). The Medicaid Single State Agency,

the Vermont Agency of Human Services, makes a capitated payment to the Medicaid department, the Office of Vermont Health Access (OVHA). Under the Special Terms and Conditions of its 1115 Demonstration, OVHA must meet all federal requirements applicable to MCOs. If OVHA's capitation revenues exceed its expenses, OVHA has broad authority to re-invest these "MCO savings" in health-related programs and services.

Federal Regulatory Authority

Until recently, states relied on 1915 and 1115 waivers to operate PCCM models. States now may operate PCCM programs under State Plan authority.

However, waiver authority would be necessary to operate a PCCM program outside of federal requirements. Alaska may want to evaluate the possibility of enrolling non-physician providers as primary care providers.

Potential Program Savings

States estimate savings from PCCM programs to range from a small (3.8 percent in Iowa) to significant (13.7 percent in Florida). Measuring actual savings can be challenging if an adequate control group does not exist to serve as the "unmanaged" fee-for-service benchmark.

If Alaska implemented a PCCM and reimbursed PCPs \$3.00 per client, per month, the aggregate annual costs would be approximately \$4 million. These costs would be offset by any savings that accrue due to enhanced access to primary care and reduced utilization of more costly services. Alaska would need to realize a reduction in Medicaid expenditures of approximately one percent in order to offset PCCM case management fees.

Premium Assistance Programs for Employer-Sponsored Insurance (ESI)

Description/Objectives

As states look for ways to more effectively support the health coverage needs of low-income workers and their families, a recent focus has been to supplement employer-sponsored insurance (ESI) through premium assistance, rather than providing direct coverage through state programs. Premium assistance programs are seen as a way to continue coverage for

existing eligibles or decrease the level of uninsured individuals without the significant cost expenditures of traditional programs.

The objective of premium assistance is to make employer-sponsored coverage more affordable for low-income residents by providing a public subsidy toward the individual monthly contribution toward employer-based coverage. In Alaska, the individual contribution toward employer-based coverage is 22 percent of the total premium, equal to approximately \$45 per month. In some cases, it may be less costly for Medicaid to pay the individual's monthly contribution than to provide benefits under the Medicaid fee-for-service program.

In addition to the individual monthly contribution, the cost effectiveness analysis would need to evaluate potential out-of-pocket costs for each policy type, which also could be subsidized by the state. Unless waived, Alaska also would be responsible for ensuring that all Medicaid-covered services are available. Therefore, if the private policy does not cover a service that is covered by Medicaid, Alaska would pay for the service as a "wrap-around" benefit. The potential costs of Medicaid wrap-around benefits also would have to be evaluated.

While ESI initiatives shift some of the burden for coverage to employers, providers may benefit from higher reimbursement from commercial carriers as opposed to Medicaid payment rates.

When the Bush Administration introduced the Health Insurance Flexibility and Accountability (HIFA) framework for Section 1115a Demonstrations in 2001, a central focus was to expand coverage through public and private collaboration.

Several states have implemented or are developing ESI programs, including Idaho, Illinois, Massachusetts, Michigan, New Jersey, Oklahoma, Rhode Island, Utah, Vermont and Virginia. However, enrollment in ESI programs remains low in all of these states. Rhode Island, which is among the most successful, has enrolled about 6,000 individuals in ESI, or less than five percent of its Medicaid population. Massachusetts has enrolled approximately 19,000 individuals in ESI, representing approximately 3.5 percent of its eligible population.

Best Practices

Examples of state ESI programs include the following:

- Oklahoma helps to offset the purchase price of insurance coverage for small businesses for a product that can be purchased on the open market. Businesses that already provide some type of health insurance coverage are also eligible.
- Louisiana offers ESI to individuals working for small employers which have not provided insurance coverage in the last six months. Louisiana subsidizes the insurance premiums for employees with families under 200 percent of the FPL. Other employees would be eligible to participate, but the state would not subsidize their participation.
- In Rhode Island, the RItE Share program helps employees pay for employer sponsored coverage. After determining whether the coverage meets state standards for a comprehensive policy, a cost effectiveness determination is then made to see whether the employee's share of the premium is less than the cost of enrolling in the traditional Medicaid program. If it is, the State then reimburses the employee directly for his or her portion of the premium.⁶⁶

Federal Regulatory Authority

Premium assistance programs can be developed using both Medicaid and SCHIP funding. Additional design options and flexibility are also available if the program is pursued under a HIFA or other 1115a Demonstration Waiver.

- *Medicaid* – Section 1906 of the Social Security Act allows Medicaid-eligible recipients to be enrolled in group health plans so long as the coverage and cost-sharing protections are the same as if the beneficiary had enrolled in Medicaid. The program, Health Insurance Premium Payment (HIPP), provides wrap-around coverage to ensure these requirements are met. However, utilization of this program must be cost effective.
- *SCHIP* – Uninsured children who have not had group coverage in the past six months can receive premium assistance when enrolled in a group health plan. SCHIP will part of, or the entire premium, for enrollment, so long as the child receives one of the

⁶⁶ *Family Matters, Volume 3, Issue 1. June, 2003.*

“benchmark” or “Secretary-approved” benefit packages. Cost-sharing requirements must also be met. States can provide wrap-around coverage if the requirements are not met by the group health plan.

- *Demonstration Flexibility* – Using HIFA, Illinois was able to waive the cost-sharing and benefit matching requirements so long as the consumer made an informed choice regarding the difference between the group health plan and direct state coverage.

*Potential Program Savings*⁶⁷

A properly designed premium assistance program can save states a substantial amount of money. A survey of six states (Iowa, Illinois, New Jersey, Oregon, Rhode Island, and Utah) found that four of the six had documented savings, with data being unavailable for the remaining two states.

- *Iowa* – Estimates a 30 percent savings for each enrolled member
- *New Jersey* – Estimates savings of \$204 per family, per month
- *Rhode Island* – Saves \$222 per family, per month (including administrative costs)
- *Utah* – Saves \$30 per enrollee, per month (\$50 subsidy versus \$80 for direct coverage)

Administrative costs for start-up and operations can be high, as a great deal of coordination is necessary regarding approval of employer plans, enrollment and financial transactions for the reimbursement of individual contributions.

Health Savings Accounts (HSAs)

Description/Objectives

Health Savings Accounts are viewed as an innovative approach to engage consumers in the decision-making process when purchasing health care, by providing incentives for them to be prudent purchasers. By making consumers responsible for part of their health care costs, HSAs are seen as a way to reduce unnecessary health care costs.

Health Savings Accounts generally must be purchased in conjunction with a high-deductible health plan (HDHP) in order to be tax-deductible. Under federal law, the HDHP must have a minimum deductible of \$1,050 for single coverage and \$2,050 for family coverage.

⁶⁷ Alker, J. “Premium Assistance Programs: How are they Financed and Do States Save Money?” *Kaiser Commission on Medicaid and the Uninsured*. (October, 2005).

Generally, the HSA/HDHP model offers individuals lower monthly premiums than traditional health care coverage, but places them at greater risk for out-of-pocket costs.

The debate over the benefit of HSAs is widespread. There is concern that since HSAs will primarily attract those who can realize the benefits of the tax deductions, and can afford cost-savings portions, leaving lower-income citizens behind. In addition, since they are more likely to attract healthier individuals, there is concern that the cost of insurance will be driven up for individuals with more health care needs. However, a Medicaid HSA may help eliminate at least part of the criticism because the lower-income individuals, who will not realize the tax deduction benefits, will still have state-provided funds set aside for a more consumer-driven approach to health care.

The basic design of a Health Savings Account under Medicaid is an individual account with a defined annual amount (e.g., \$2,500), from which all health care purchases are made. Once the account is exhausted, the member may be responsible for cost-sharing, whether by point-of-service co-payments or a defined deductible amount. If the account has funds remaining at the end of the year, the program may permit the participant to use the remainder for other health-related services or carry-forward the balance to subsequent years.

The Deficit Reduction Act authorized ten states to implement programs to provide Medicaid coverage through “Health Opportunity Accounts” in conjunction with high-deductible health plans. Under this model, Medicaid would establish individual accounts with up to \$2,500 annually per adult and \$1,000 annually per child. An individual deductible then would be established, equal to 10 percent of the account value (\$250 per adult and \$100 per child). Once the value of the account is exhausted, individuals would be required to meet their annual deductible before Medicaid’s obligation continues.

Design of an HSA program for Medicaid participants presents some unique challenges. As an example, states need to determine what happens to funds in the HSA account when a person is no longer eligible for Medicaid. One option is to permit individuals to use HSA funds to purchase individual or employer-sponsored coverage. Another option is to “retain” the account balance in the event that the individual again becomes eligible for Medicaid at a future date.

Best Practices

The state of Florida recently enacted a program under a Section 1115a waiver that maximizes predictability by capping the amount of funds allotted to each beneficiary and then working with health plans to tailor packages that fall within these cost limits. The state will pay the health plan a risk-adjusted premium which provides for all Medicaid mandatory services and other optional services.

Beneficiaries who practice certain “healthy” behaviors will find funds deposited into Enhanced Benefit Accounts. Beneficiaries can then use these funds to help offset health care costs that may not be covered by their insurance program. Individuals with access to insurance through the private market (workplace or self-employed), may also use the state funds to offset their premiums. The state also is setting-aside dollars to reimburse providers who have treated the uninsured. (Florida’s program is beginning as a sub-state pilot, though it has authority under Section 1115a to eventually take the program state wide.)

South Carolina has requested a waiver to institute a plan similar to the one in Florida, whereby eligible recipients would be able to purchase state-approved health insurance plans using their Personal Health Accounts. Similarly, beneficiaries could opt-out of the state plans but use the provided premiums to offset the cost of employer-sponsored insurance.

Federal Regulatory Authority

Several states have considered the development of Health Savings Accounts as part of their Section 1115a Demonstrations. As previously referenced, ten states will have the opportunity to implement “Health Opportunity Accounts” under legislative authority granted as part of the Deficit Reduction Act.

Potential Program Savings

While determining potential savings is difficult, HSAs are useful in that costs are more predictable than in FFS models. Because the state could design a program where a certain, pre-set dollar amount is allotted to each beneficiary, by approximating the number of eligible recipients, the state would then be able to calculate the total cost of the program.

Financing of Health Care for American Indians/Alaska Natives

Description/Objectives

The Alaska Native Health Care Delivery system is organized with the objective to meet the health care needs of Native Alaskans. The system faces challenges with regard to program funding as it relates to service delivery and the investment in infrastructure. Because Native Alaskans access tribal health services regardless of whether they are eligible for Medicaid, it is often difficult to enroll individuals in the Medicaid program.

The State may wish to further explore a complete transformation of the existing Medicaid financing arrangement. The new Medicaid-Tribal Health Delivery System would operate as a managed delivery system for the financing and delivery of Medicaid services. Under this arrangement, Medicaid funding would be based on the full range of Medicaid-eligible services for Medicaid-eligible Native Alaskans. In exchange for payment, the tribal health entity would be responsible for ensuring access and delivery of all Medicaid-eligible services.

The managed delivery model would address the following issues:

- Re-aligns the federal government's commitment to serve Native Alaskans with realities of the Alaska tribal health delivery system
- Encourages tribal providers to develop the capacity to meet all health care needs, including behavioral health, substance abuse treatment, and long-term care services
- Provides flexibility with regard to the types of services supported at the community level (e.g., community behavioral health aides, home-based care)
- Provides a sustainable funding stream for the tribal health system
- Potentially addresses the challenges tribal providers face regarding Medicaid claiming and Medicaid enrollment
- Reduces state funding of Medicaid services by approximately \$80 million annually, some of which could be used to facilitate infrastructure development

Alaska could develop a model which enables the tribal health system to operate as a managed care organization (MCO). Alaska has some experience with this model, having adopted it for the Yukon Kuskokwin Corporation in 1995 for the delivery of developmental services. As an MCO, the tribal health system would provide or arrange for the provision of all Medicaid-eligible services in exchange for a capitated payment.

The MCO would need to comply with all Medicaid managed care regulations, as defined by the Balanced Budget Act of 1997.

One of the challenges of this approach relates to the legal and practical ability of the tribal health system to assume risk. Because the tribal system is a public health care system, there may be opportunities for the State of Alaska and the tribal MCO to share risk. One option for a shared-risk model would be to place some of the saved state dollars into a reserve account, with defined parameters under which the tribal MCO could access the funds.

Another challenge of this model is the change in operations and infrastructure for the tribal health system. There may be opportunities for the tribal system to contract with the State for certain functions, such as claims processing. Under this approach, private providers would continue to submit claims to the State's Fiscal Agent. However, payments would be withdrawn from a tribal MCO fund.

Best Practices

Alaska's Medicaid program stands apart from all others, with 40 percent of its enrollment comprised on American Indians and Alaska Natives. A complete restructuring of Medicaid funding for AI/ANs has not been implemented in other states.

Federal Regulatory Authority

Authority to operate a quasi-public MCO model for the tribal health system would need to be granted under a Section 1115 Demonstration. Because this approach is a significant departure from other initiatives and would involve both the Centers for Medicare and Medicaid Services and the Indian Health Services, the approval process likely would be involved and detailed.

Other challenges may arise out of federal laws governing the operation and financing of Indian Health Services. These laws would need to be evaluated further as part of assessing

the feasibility of this approach. Opportunities to obtain Congressional authority also should be explored.

Potential Program Savings

Development of a managed delivery system that is appropriate for Alaska is likely to produce savings resulting from the flexibility to provide services that are culturally appropriate and rooted in the community-based system.

Because Medicaid payments are made to the tribal MCO, funding would be 100 percent federal dollars, producing annual state savings of approximately \$80 to \$100 million.

Comprehensive Reform – Implementation Considerations

The Deficit Reduction Act (DRA) of 2005 allows states more flexibility to change its Medicaid programs. By allowing changes in benefits and cost-sharing arrangements to be administered through state plan amendments, rather than the waiver process, it is anticipated that changes can occur more rapidly. In addition, state plan amendments are not required to show budget neutrality.

States are now allowed to impose cost-sharing arrangements on all recipients, including those that receive pharmacy services (some groups will be protected when using preferred drugs). Medicaid programs can also use “benchmark” plans for certain eligible groups that were previously only available in SCHIP.

The DRA expands the range of allowable cost-sharing programs for Medicaid. Higher than nominal co-payments can be imposed on many beneficiaries and providers have the right to refuse care if the co-payment is not made at time of service. Premiums can be charged to beneficiaries with family incomes at or above 150 percent of FPL. (Total cost-sharing cannot exceed five percent of a family’s income.)

While the DRA offers states additional flexibility regarding program design, Section 1115a Demonstrations permit the greatest flexibility with regard to program restructuring. In exchange for this flexibility, Alaska would need to commit to a five-year expenditure limit.

Ultimately, the decision over whether to pursue a waiver should be made based on what Alaska hopes to achieve through Medicaid reform. The reform planning process should begin at the broadest possible level, working towards a reform plan that best meets Alaska's programmatic and fiscal objectives. Once the reform plan has been developed, an assessment can be made to determine what aspects of the plan may be implemented within the parameters of federal regulations and what aspect would require federal waiver authority. Alaska then would be in a position to determine the best approach for securing federal approval of its plan.